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OMIC DIGEST

Ophthalmic Mutual Insurance Company

Ophthalmic Risk Management Digest

A Safe Haven for Doctors During Hard Times

By Robert Widi and Thomas L. Ghezzi, FCAS, MAAA

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In spring 2001, when the *Digest* published "Hard Times Ahead for Doctors and Carriers," written by then OMIC President and CEO James F. Holzer, JD, many in the medical malpractice insurance industry were unprepared to make the tough business decisions necessary to address deteriorating market conditions. In less than seven years, the median malpractice jury award had doubled from $473,000 in 1996 to $1,011,000 in 2002. Meanwhile, the median malpractice settlement rose 45% from $350,000 to more than $500,000 during the same period.[1]

Unfortunately for a number of malpractice carriers and their physician-insureds, Mr. Holzer's warnings of an impending crisis in availability and affordability of coverage proved to be remarkably prophetic. Several major insurance companies imploded when it became clear they had seriously underpriced their product to buy market share and could not afford to pay their escalating claims costs once the market soured.

Based on net written premium for 1996, six of the then top ranked twenty writers of medical malpractice insurance in the United States have since exited the market, some voluntarily shifting their focus to more profitable lines of insurance, while others were forced into state receivership. Eight more have had their A.M. Best rating downgraded **(Figure 1)**. Inadequate capitalization was cited as the primary issue in all these downgrades. Aggressive growth and expansion into new markets in the mid to late 1990s put these companies in the unfavorable position of not having sufficient surplus to cover their increased business risks.

During this volatile period, OMIC's continued profitability and reaffirmation of its A- (Excellent) financial rating allowed the Company to provide a safe haven for many of those ophthalmologists who found themselves nonrenewed or canceled by their malpractice carrier. As a result, OMIC experienced a

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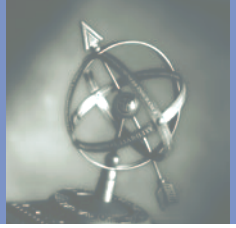

Eye on OMIC

OMIC

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

OMIC, not the Academy, is solely responsible for all insurance and business decisions, including coverage, underwriting, claims, and defense decisions.

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Another Year of Growth and Profitability for OMIC

While the medical malpractice industry in general continues to be shaken by severe underwriting losses and financial rating downgrades, OMIC has bucked the trend and posted positive year-end earnings for the sixteenth consecutive year. In more good news, A.M. Best reaffirmed OMIC's A- (Excellent) rating for 2004 and views its rating outlook as "stable," citing OMIC's conservative management, adequate capitalization, and "strong leadership position within the ophthalmic professional liability market." This recognition by A.M. Best validates the Company's history of fiscal conservatism, prudent underwriting, effective risk management, and aggressive claims handling. Year after year, better-than-average loss experience has enabled OMIC to remain solvent, turn a profit, and provide a superior insurance program for ophthalmologists at a competitive price.

OMIC's year-end 2003 results exceeded industry averages and showed a significant improvement over the prior year's results. Direct written premium increased 37% to $38 million, while after-tax net income more than doubled from $0.9 million in 2002 to $2 million in 2003. Driving these favorable results was OMIC's 79.5% loss and loss expense ratio, which outperformed the national average of physician-owned carriers by 24 points. Company efforts to control operating costs brought the expense ratio down by nearly 4 points last year, even as OMIC continued to grow by another 206 policyholders. Two years ago, OMIC employed a staff of 27 to manage a book of business totaling $20 million; today, a staff of 31 manages $38 million in premium.

Admitted assets increased 18.7% to $104.5 million during 2003, and surplus grew by $3.5 million to $25.3 million. The Company continues to focus on increasing its policyholder surplus level to ensure that it keeps pace with premium growth and provides adequate protection against unexpected losses and the increased risk that accompanies a larger policyholder base. Double-digit policyholder growth, along with a 95% retention rate, has caused OMIC's net written premium to grow faster than surplus in recent years.

Because of this and the normal delay for increased premiums to generate profits that can flow through to surplus, the decision was made to not declare policyholder dividends for 2003. While OMIC has returned nearly $2.5 million in dividends to policyholders over the years, it would not be a prudent business decision to distribute dividends at this time. The lead article, "A Safe Haven for Doctors During Hard Times," discusses other actions that have been taken to ensure OMIC's continued financial viability during hard market cycles such as we are now experiencing.

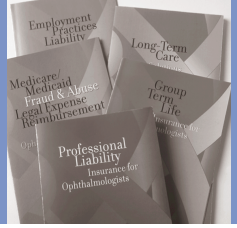
Thanks to the loyal support and active participation of its member-insureds, OMIC remains committed to providing a safe haven for ophthalmologists for many years to come.

– Ricci A. Rascoe, OMIC Controller

OMIC Wants Your Email Address

In an effort to expand the use of electronic mail for more cost-efficient and timely policyholder communications, OMIC is undertaking the collection of email addresses for all member-insureds. OMIC uses broadcast email to send periodic *E-Bulletin* announcements of OMIC policy modifications and coverage enhancements as well as ophthalmic product alerts and recalls. Like other contact information, email addresses will be kept strictly confidential and used solely for OMIC business purposes. OMIC currently has approximately 1,300 valid email addresses on file and almost 3,300 insureds.

Please watch your mail this summer for a letter from OMIC requesting your email address. To provide or update this information online, please visit the OMIC web site, go to the Members Area section, and click on the Change of Address page. For security purposes, you will be asked your name and OMIC Risk Number. Your risk number consists of two letters followed by five numbers and will be printed on the letter you receive from OMIC. If you prefer, you may complete the form at the bottom of the letter and fax it back to OMIC. If you already know your risk number, which can be found on your Policy Declarations Page, you may go online and fill in your email address at any time.



Limits of Liability

By Kimberly Wittchow, JD
OMIC Staff Attorney

Press coverage of the industry-wide rise in medical malpractice claims frequency and severity is abundant. This has many insureds questioning whether their current limits of liability are adequate for the increasingly litigious environment in which they practice. To help insureds assess their coverage limits and needs, this article will address what is meant by limits of liability, how to select limits, and how changing limits affects coverage if a claim arises.

Your limits of liability are the maximum dollar amounts of indemnity OMIC will pay on your behalf as a result of covered claims. Indemnity is the amount of damages awarded in a lawsuit or agreed to in a settlement between the parties. OMIC will pay your reasonable defense costs *in addition to* your liability limits.

All OMIC insureds have two separate limits: the *per claim*, or "medical incident," *limit* and the *aggregate limit*. The *per claim limit* is the maximum amount of indemnity OMIC will pay per insured for all damages caused by any one medical incident, or by any series of related medical incidents involving any one patient, regardless of the number of injuries, claimants or litigants, or the number of claims (notices, demands, lawsuits) that result. The *aggregate limit*, on the other hand, is the maximum amount OMIC will pay per insured for all claims made and reported during the policy period.

How to Select Limits

There are several factors to consider when selecting limits of liability. The limits you require may vary with changes in your state's malpractice liability climate, the procedures you perform, and the makeup of your practice. Therefore, you should continually assess your current needs and corresponding coverage.

First, review the claims statistics for ophthalmologists. For example, as of February 2004, OMIC's average indemnity payment was $130,166 and its largest indemnity payment was $1.8 million.

Second, consider your state's risk relativity. When OMIC looks at risk relativity, it compares the number of insureds, the number of total claims, and the average indemnity paid per claim in each state. Under this analysis, due to the fact that OMIC has a large number of insureds in these states, OMIC's highest claims activity is currently in California, Texas, and Illinois. For selecting limits, however, a better way to look at risk relativity might be to compare the average rate of claims per insured per state. OMIC insureds in Louisiana and Michigan currently experience the highest claims frequency.

Third, find out what liability limits your peers are carrying. The majority of OMIC insureds (65%) carry $1 million per claim/$3 million aggregate limits. Higher limits of $2 million per claim/and either $4 million or $6 million aggregate limits are selected by 21% of insureds. OMIC's lowest offered limits of $500,000/$1.5 million are carried by 6% of insureds, while 4% select the highest limits OMIC offers, $5 million/$10 million. The remaining 4% of insureds carry other combinations of limits, including lower limits available exclusively to physicians who participate in their state's patient compensation fund.

Fourth, consider the risks related specifically to your practice. Is your subspecialty one in which there is high claims frequency (e.g., cataract surgery) or large damage awards (e.g., neonatal care)? Do you share your coverage and limits with any ancillary employees or your sole shareholder corporation? On the other hand, have you ceased performing most surgical procedures or limited your practice to part time?

Fifth, assess your level of risk aversion. Would higher limits make you feel more secure because of the large indemnity cushion or less secure because of the "deep pockets" potentially discoverable by the plaintiff?

Finally, check with your hospital and state licensing board because they may specify the minimum amount of coverage you must carry. Also note that OMIC generally requires all OMIC-insured physicians in practice together to carry the same liability limits. The practice's legal entity cannot be insured at higher limits than those of the physicians.

Which Limits Apply to a Claim?

You should consider how changing your limits will affect the amount of indemnity available to you if a claim should arise. The limits of liability that apply to a claim are those limits that are in effect as of the date the claim is first made against you and first reported in writing to OMIC. In other words, if you increase or decrease your coverage after you've reported a claim made against you to OMIC, the limits that you carried when you reported the claim, not the new limits, will be applied to the claim.

Subject to underwriting review and approval, you may increase or decrease your limits of liability at any time during the policy period (although OMIC typically does not consider requests to change policy limits while a claim is pending). If you are in group practice, discuss this desired change with your practice administrator and partners. Your OMIC underwriter can provide you with the most recent OMIC data to help you determine which limits are appropriate for you. However, OMIC representatives are not in a position to offer you advice. If you need further assistance, please consult your personal attorney.

A Safe Haven for Doctors During Hard Times

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surge in new business activity and unprecedented growth as the number of OMIC policyholders climbed from 2,150 at year-end 2000 to 2,432 in 2001 and 2,968 in 2002, annual increases of 13% and 22%, respectively. Policyholder growth continued upward in 2003, although at a more moderate rate of just under 7%. As of June 1, 2004, OMIC's policyholder count stood at 3,285, representing 31% of the eligible national ophthalmology market and making OMIC the largest insurer of ophthalmologists in the U.S.

A Measured Path to Rate Adequacy

OMIC's ability to remain financially and operationally sound while many of its competitors faltered can be attributed to several factors:

- A single-specialty focus and expertise in ophthalmology;
- Adherence to consistent and conservative underwriting standards;
- Attention to rate level adequacy, even during the competitive 1990s when OMIC resisted the price cutting tactics so prevalent during the "soft" market.

This last point is particularly significant because while other carriers have been forced to implement drastic rate action in an attempt to regain their financial footing, OMIC has taken a more measured path to maintaining rate adequacy. Those ophthalmologists who stayed with OMIC throughout the 1990s and resisted the temptation to chase lower (and actuarially inadequate) rates have been spared the recent scramble for replacement coverage as insurers exited the market altogether or imposed rate increases upward of 100%.

Unfortunately, no carrier is immune to the effects of the U.S. tort system. As patients increasingly turn to the courts for restitution of unsatisfactory medical outcomes and juries increasingly award large plaintiff verdicts, malpractice carriers will be forced to respond with higher premiums. The difference with OMIC is that these necessary price increases have been far less than those implemented by other insurers. In its four largest states (CA, FL, IL, TX), where 40% of insureds practice, OMIC has kept rate increases significantly lower than other major insurers **(Figure 2)**.

Also, a rate comparison survey of 20 major competitors in early 2004 showed that OMIC's rate was the lowest in 67% of 46 randomly selected territories and its average premium was lower than the average for ophthalmology in every region of the country. Clearly, OMIC's disciplined, conservative approach and single-specialty focus are benefiting the Company and its insured ophthalmologists.

The Importance of Surplus

Throughout its sixteen-year history, OMIC has always posted positive earnings. This extremely favorable track record is in stark contrast to the medical malpractice insurance industry in general, which experienced net losses in each of the last three years. Positive earnings have enabled OMIC to grow or maintain its overall "policyholder surplus" level each year since inception. Policyholder surplus is important because it provides a source of funds that an insurance company is required by regulatory agencies to

	2004	2003	2002	2001	2000
A++	0	1	1	1	1
A+	0	0	0	0	0
A	10	11	13	15	16
A-	17	18	24	26	25
B++	9	7	6	8	5
B+	3	4	3	3	6
Total Secure	**39**	**41**	**47**	**53**	**53**
B	4	3	1	2	1
B-	2	1	2	0	0
C++	1	0	0	0	1
C+	0	1	0	0	0
C	0	0	1	1	0
D	0	0	0	1	1
E	1	2	0	0	0
F	3	2	2	0	0
Total Vulnerable	**11**	**9**	**6**	**4**	**3**
NR-4*	5	5	5	1	1
Unrated**	7	6	3	4	4

* NR-4 companies were assigned a Best's rating but request that it not be published because they disagree with the rating.
** Unrated companies do not qualify for a Best's rating because of their limited financial information, small level of surplus, lack of sufficient operating experience, or their dormant or run-off status.

Figure 1 A.M. Best Rating Distribution for Medical Malpractice Carriers
Between 2000 and 2004, there was an alarming decrease in the number of carriers with a secure financial rating and a corresponding increase in the number of carriers with a vulnerable rating. Inadequate capitalization, resulting from insufficient policyholder surplus levels, was cited as the primary issue in all downgrades.

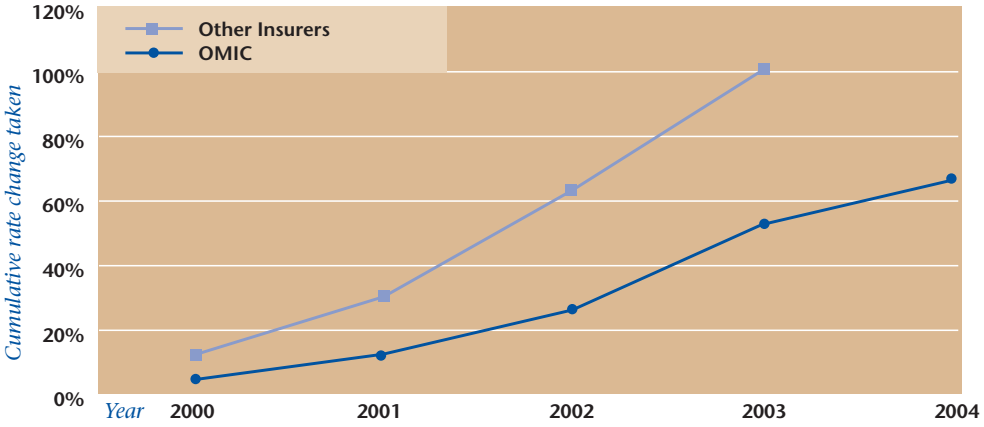

Figure 2 Cumulative Rate Change in OMIC's Four Largest States
OMIC's average rate increases in its four largest states (CA, FL, IL, TX) have been well below the increases implemented by other carriers. Cumulatively through 2003, other insurers doubled their rates in these states.

set aside for unexpected losses. Maintaining an appropriate level of surplus is key to a company's long-term reliability. A company with a high level of surplus is more secure than one with a low level of surplus, all other factors being equal. Many of the insurers that cut back on writing new business or exited the market entirely had to do so because of inadequate surplus.

Surplus is often viewed in combination with a measure of the amount of business that an insurer does. A commonly used ratio to measure surplus within the insurance industry is the "premium-to-surplus" ratio. This ratio is simply a company's premium divided by its policyholder surplus. An acceptable ratio for a medical malpractice insurance carrier is currently in the 100% to 125% range. OMIC falls within this acceptable range at 116%.

In recent years, OMIC's premium-to-surplus ratio has approached the higher end of the range due, in large part, to its willingness to fill the coverage void left by financially troubled carriers. This expansion of business to meet the needs of ophthalmologists, coupled with OMIC's very high retention rate, has caused premium to grow faster than policyholder surplus. OMIC remains committed to extending coverage to qualified applicants while maintaining adequate levels of capitalization. To do so, OMIC must continue to carefully price its insurance coverage so surplus growth can keep pace with – or even exceed – premium growth, thereby ensuring that the premium-to-surplus ratio stays in the desired range for the long-term health of the company. An actuarially sound pricing structure is an important part of a larger effort to strengthen rates and build surplus.

Short-term Savings vs. Long-term Stability

At the time OMIC was created, ophthalmologists were in the throes of an insurance crisis much like the one we are experiencing today. Frustrated by the commercial carriers that were abandoning them and the multi-specialty carriers that were overcharging them to subsidize higher risk specialties, a group of American Academy of Ophthalmology members sought relief through the Risk Retention Act of 1986. Their goal in forming OMIC as a sponsored program of the Academy was to provide a long-term stable source of insurance protection for Academy members priced according to ophthalmology's actual exposure. Under the Academy's continued sponsorship, OMIC has become one of the nation's most respected single-specialty medical liability carriers and the industry leader in ophthalmic-specific claims handling, risk management, and underwriting.

During the current crisis, a great number of Academy members have found OMIC to be a refuge from the turmoil plaguing the rest of the industry. In some cases, every other carrier in their state has either left the market or ceased writing new business. Unfortunately, when the competitive market returns, some of these ophthalmologists will forget the difficult lessons of the past and put themselves at financial risk again by switching to carriers that offer short-term savings over long-term rate stability. In doing so, they will encourage the reentry into the market of companies that have little or no loyalty to their physician-insureds and that have a proven track record of abandoning or pricing their customers out of the market when profit margins decline. Rewarding the predatory actions of these companies feeds into the next hard market cycle and contributes to a deteriorating malpractice environment.

Ophthalmologists have it within their power to help break this cycle by purchasing their professional liability coverage from carriers that are committed to insuring the ophthalmic community for years to come. If ophthalmologists apply the lessons they have learned during this malpractice crisis to making more informed insurance choices in the future, these hard times will not have been in vain.

1. "Medical Malpractice: Verdicts, Settlements, and Statistical Analysis." *Jury Verdict Research Report*. 3/22/2002.

Watch for Warning Signs of a Missed Diagnosis

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

Allegation

Failure to diagnose optic glioma, resulting in delay in surgical removal and blindness in right eye.

Disposition

Settled on behalf of defendant ophthalmologist.

Case Summary

A three-year-old was referred to the insured ophthalmologist with a complaint of headaches. The mother reported an out-turning right eye and said the child needed to sit directly in front of the TV to see. The ophthalmologist noted nystagmus, diagnosed hyperopia OU and exotropia, issued a prescription for a full cycloplegic refraction, and instructed the mother to bring the child back in three months or sooner if headaches and/or blurred vision persisted. Four months later, the ophthalmologist noted resolution of the headache, stable exotropia and hyperopia, slow-beating nystagmus, and stable gaze. The patient was to continue wearing the glasses and return in six months. Three months later, the mother brought the child in when he failed his school eye examination and reported trouble with the glasses. VA was felt to be unreliable but measured 20/30 OD, 20/70 OS. A low-grade allergic conjunctivitis was noted and treated. When he returned as requested for a refraction the following month, the child was failing the school eye exam with and without glasses. Refraction was performed with a mild hyperopic correction; optic pallor was noted on the fundus examination OD. A trial of patching was planned, after which the child was to return for evaluation. When the mother reported problems with the patching exercise a week later, the ophthalmologist referred her to the local children's hospital. A work-up there revealed HM to LP only, with marked divergent drift and pale optic disc OD. Neuroimaging studies revealed an optic glioma, which was treated with surgery, radiation, and chemotherapy.

Analysis

In order to prove malpractice, the care rendered must deviate from the standard and be the cause of the patient's alleged damages. Experts criticized the insured's failure to refer the child to a specialist for nystagmus, found on the initial exam, and optic pallor, noted seven months later. The validity of the visual acuity measurement was also challenged, given the precipitous change over a one-week period. Defense experts noted, however, that the patient did benefit from the treatment for exotropia and, more importantly, that earlier diagnosis of this slow-growing tumor would not have affected the treatment or the outcome. The insured ophthalmologist agreed with the defense attorney that these shared concerns, coupled with the child's poor outcome, could lead to a substantial jury verdict. A decision was therefore reached to settle the case.

Risk Management Principles

"Failure to diagnose" claims are common and account for half of OMIC's top ten indemnity payments. From both a patient safety and liability perspective, it is important to rule out the worst possible diagnosis as part of the diagnostic process. One of the simplest formulations of this axiom is the "witty" or "WIT-D" approach.[1] Include the worst thing (W) the patient could have in the differential diagnosis; collect the information (I) needed to rule it in or out; tell (T) the patient and other members of the health care team of your differential diagnosis, planned treatment, and any symptoms that should be reported to you; and document (D) your care, decision-making process, and instructions. In this case, nystagmus should have prompted a referral (I) to a neuro-ophthalmologist to rule out a CNS process (W); the optic pallor also required further work-up. There are usually many warning signs of a missed diagnosis. These include repeated, ongoing, or worsening complaints (worsening visual acuity); treatment that does not resolve complaints (kept failing school eye exams); and a diagnosis that does not account for the symptoms (neither the nystagmus nor the optic pallor could be attributed to the hyperopia or exotropia). Such warning signs should prompt the physician to start over by reviewing all chart notes, using the WIT-D approach, accounting for all symptoms, and seeking a consultation or referral.

1. Buppert, Carolyn. "A Witty (WIT-D) Approach to Avoiding Mistakes." *The Gold Sheet* 4(6), 2002. www.medscape.com/viewarticle/438381.

Informing Patients About Your Surgical Experience

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

More than many specialties, ophthalmology evolves rapidly through the development of new procedures, techniques, and devices. While each innovation holds the promise of improved outcomes for the patient, it also introduces new areas of risk as ophthalmologists and their staff learn to incorporate the changes into their practice. OMIC policyholders often call the Risk Management Department to ask if and how they should talk to their patients about their training and experience.

Q The ambulatory surgery center (ASC) where I perform cataract surgery switched phacoemulsification machines over the objections of many ophthalmologists. While I have completed the training course offered by the manufacturer, I have not yet used the new machine on my own patients. Do I have a legal duty to tell my patients?

A Ophthalmologists are aware of their legal and ethical duty to obtain the patient's informed consent for surgery. The surgeon discharges this duty by personally discussing the indications, risks, benefits, alternatives, and known complications with the patient, who orally agrees to proceed with the planned procedure. The discussion and agreement are then documented by noting the discussion in the medical record and by asking the patient to sign a consent form. As we state in OMIC's new online course, *Informed Consent for Ophthalmologists*, there is a small body of emerging case law governing situations where a surgeon isn't truthful about his or her training and experience, particularly as it relates to board certification and/or experience performing a particular procedure. If a patient is injured as a result of a surgical procedure, some courts have effectively "thrown out" the consent form if it is later proved that the surgeon, *when asked*, knowingly misstated his or her skill, training, certification, and/or experience. Thus, the ethical considerations of lying to the patient during the consent process could conceivably pose serious legal consequences. There is no clear consensus, from a legal standpoint, about whether or not the physician has a duty to offer this information.

Q What are the consequences of not telling the patient about my experience?

A Learning about a surgeon's limited experience *after* a poor outcome or complication could seriously compromise the physician-patient relationship. The ensuing lack of trust in the physician could also hinder the provision of care needed to treat the complication. Patients may feel betrayed or worry that the physician was experimenting on them. The resultant anger could well prompt a lawsuit for malpractice and lack of informed consent. The patient would likely allege that the surgeon's level of expertise would have made a difference in the decision to undergo surgery, and his or her attorney would argue that a "reasonable person" would have considered this information "a material fact" that should have been disclosed.

Q I believe I have an ethical duty to disclose my training and experience, but I am not sure how to proceed. What do you recommend?

A Simply provide the facts about your training and experience as they relate to the particular procedure. In the example given here, while explaining the role of the phacoemulsification machine in the lens extraction, inform the patient that the ASC has recently changed machines. Disclose your overall experience with cataract surgery as well as your recent training on this machine. If certain complications are more likely to occur with the new machine or during your learning curve, tell the patient what they are and how you will manage them if they do. If the patient is not comfortable proceeding, help him or her find alternative sources of care. Regardless of how you feel about the ASC's decision, do not share your criticisms with the patient. Instead, address your concerns to the appropriate leader on the medical staff.

Q Should I tell a patient that I am using a newly approved IOL such as the Crystalens?

A It would be prudent to do so. As part of your discussion of the risks, benefits, and alternatives to this IOL, explain why in your professional judgment it is the best one for this particular patient. If you are relatively inexperienced in inserting it, consider explaining that as described above. Patients appreciate knowing the financial implications of your choices, so inform them of any known health insurance or payment issues. As with any new device or procedure, be sure to inform the patient if long-term outcomes are not yet known and explain that there may be unforeseen complications. If you are using the device in an off-label manner, the patient should be so informed.

For more information about informed consent, see OMIC's online course or the following online articles, "Practicing Beyond One's Expertise: The Road to a Lawsuit" and "New Surgical Advances Come with Liability Risks." These can be found at **www.omic.com**.

Calendar of Events

OMIC continues its popular risk management seminar program this summer and fall in conjunction with ophthalmic society meetings. CME credit and OMIC's risk management premium discount are available for attending most OMIC-sponsored seminars or for participating in one of OMIC's three online courses *(Ophthalmic Anesthesia Risks, EMTALA and ER-Call Liability*, and *Informed Consent for Ophthalmologists)* at **www.omic.com**.

OMIC's newest online course, *Informed Consent for Ophthalmologists*, provides an overview of the doctrine of informed consent as it applies to various ophthalmic practice settings. The course also illustrates practical ways that ophthalmologists can support the consent "process" to foster more effective patient/provider communications as well as improve the defense of malpractice claims.

Upon completion of a seminar or online course, OMIC insureds will receive a 5% risk management discount to be applied upon renewal. Seminars that qualify for OMIC's 10% double risk management discount are indicated with an asterisk. Insureds must be a member of the cosponsoring society to earn the special 10% discount. Please note that insureds are normally limited to one risk management discount per premium year.

July

10 *The Risks of Telephone Screening and Treatment*
Southeastern Regional Scientific Symposium for AL, GA, KY, NC, SC, TN, WV
Amelia Island Plantation Resort, Amelia Island, FL
2–4 pm
Register by calling (919) 833-3836 or (615) 794-1851

31 *The Risks of Telephone Screening and Treatment*
Women in Ophthalmology*
Stein Eriksen Lodge, Park City, UT
Noon–2 pm
Register with Denise Wilson, (415) 561-8523 or dwilson@aao.org

August

29 *The Risks of Telephone Screening and Treatment*
Florida Society of Ophthalmology*
Grandlakes Ritz Carlton Hotel, Orlando, FL
7:20–8:10 am
Register with Paula Baumgardner at FSO, (904) 998-0819

TBA *Research and Clinical Trials: Patient Safety and Liability Risks*
OMIC
Nationwide audioconference originates from OMIC, San Francisco, CA
Time TBA
Register with Linda Nakamura at OMIC, (415) 202-4652, (800) 562-6642 ext. 652, or lnakamura@omic.com

September

21 *Responding to Unanticipated Outcomes*
California Academy of Ophthalmology*
Statewide audioconference originates from OMIC, San Francisco, CA
Time TBA
Register with Linda Nakamura at OMIC, (415) 202-4652, (800) 562-6642 ext. 652, or lnakamura@omic.com

24 or 25 *The Risks of Telephone Screening and Treatment*
Three State Meeting for OK,* KS, AR
Big Cedar Lodge, Branson, MO
Time TBA
Register with Mike Duncan at OAO, (512) 370-1504

October

23-26 *Academy/OMIC Insurance Center Exhibit*
Hall G, Booth 3439
American Academy of Ophthalmology (AAO) and European Society of Ophthalmology (SOE) Joint Meeting
Morial Convention Center, New Orleans, LA

24 *OMIC Forum: Glaucoma Malpractice Claims*
AAO/SOE Joint Meeting
Sheraton New Orleans, New Orleans, LA
10 am–Noon
Register with Linda Nakamura at OMIC, (415) 202-4652, (800) 562-6642 ext. 652, or lnakamura@omic.com

26 *Difficult Patient Scenarios*
American Academy of Ophthalmic Executives
AAO/SOE Joint Meeting
Morial Convention Center, New Orleans, LA
3:15–4:15 pm
Register with AAOE, (415) 561-8500

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

OMIC

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