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OMIC DIGEST

Ophthalmic Mutual Insurance Company

Ophthalmic Risk Management Digest

Forensic Consulting: From Immunity to Liability

By Kimberly Wittchow, JD

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

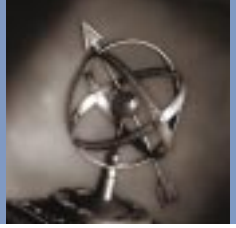
As reimbursements continue to diminish, ophthalmologists are turning to forensic consulting work to bolster their bottom line and add variety to their practice. The Physician Insurers Association of America recently reviewed approximately 18,000 medical malpractice cases and found that the average cost of hiring a defense expert is $5,486. Providing expert services in just five cases a year could boost a physician's annual income by more than $25,000. With the added income, however, physicians are assuming new responsibilities and additional liability risks. This article tracks the evolution of forensic consulting legal liability and possible disciplinary action by professional associations for violation of their ethical guidelines governing expert witness testimony.

Forensic consulting covers a variety of services, from performing case reviews to conducting independent medical exams (IMEs). Providing expert witness testimony, in particular, is becoming increasingly popular. Both federal and state jurisdictions allow qualified expert witnesses to testify if their specialized knowledge will help the trier of fact understand the evidence presented. The use of experts in the U.S. judicial system is extremely common and their influence on the outcome of trials is well accepted.

Not long ago, expert witnesses were considered friends of the court. The purpose of their testimony was to clarify and objectively explain complicated matters to the fact finder, not to assist one party in winning the case. Like lay witnesses, experts had absolute immunity from civil liability for anything they said on the witness stand. This immunity developed in English common law to encourage witnesses to provide complete and unfettered testimony in court without fear of retaliatory lawsuits by parties who were disadvantaged by their testimony. In particular, the courts wanted to

continued on page 4

In This Issue. . .



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.

OMIC
655 Beach Street
San Francisco, CA
94109-1336

PO Box 880610
San Francisco, CA
94188-0610

Phone: 800-562-6642
Fax: 415-771-7087
Email: omic@omic.com
Web: www.omic.com

Academy/OMIC Insurance Center Coming to Anaheim

Insurance is a significant overhead expense for many ophthalmologists and choosing the right insurance protection can be a time consuming and confusing process. The Academy/OMIC Insurance Center at the American Academy of Ophthalmology Annual Meeting in Anaheim will provide OMIC insureds and other Academy members with an opportunity to consult with experts familiar with the Academy's sponsored professional liability, business liability, life, health, and disability insurance programs. Representatives from OMIC, Medical Risk Management Insurance (MRMI), and Marsh Affinity Group Services will be available to answer questions and provide current rate and coverage information on 15 insurance programs now available to Academy members.

The Academy/OMIC Insurance Center will be located in exhibit hall B, booth 1239, adjacent to the Academy's Resource Center.

Mock Litigation

What's causing the current medical malpractice crisis and what's being done to fix it will be the topic of this year's *Mock Litigation*, jointly sponsored by OMIC's Risk Management Committee and the Academy. Factors such as increasing frequency of claims, unrealistic jury verdicts, the rising cost of defending claims, and updates on state and national tort reform efforts will be explored. The program will be held from 11 am to 2 pm, Sunday, November 16, in the Coast Anaheim Hotel, Park Plaza Ballroom.

In conjunction with the American Academy of Ophthalmic Executives (AAOE), OMIC will participate in a roundtable discussion, *How to Avoid Malpractice Suits Related to Telephone Care*, 7:30 to 8:30 am, Sunday, November 16, and an instruction course, *Medical Malpractice*, 9 to 10 am, Monday, November 17. Open to ophthalmologists and ophthalmic administrators, this overview course will consider a host of risk management issues related to ambulatory surgery centers, such as credentialing, staffing, equipment, and emergency response. Both AAOE programs will be held in the Anaheim Marriott Hotel.

Insureds who attend either the *Mock Litigation* or *Medical Malpractice* instruction course (AAOE Course 343) are eligible for OMIC's 5% risk management discount and CME credit. The *Mock Litigation* is free for insureds and $75 for non-insureds. Register for the *Mock Litigation* by calling OMIC, (800) 562-6642, ext. 652. *Medical Malpractice* is $25 in advance and $35 onsite. Register for the *Medical Malpractice* instruction course or *Telephone Care* roundtable by calling AAOE, (415) 561-8500. OMIC's 5% risk management discount is not available for attending the roundtable discussion.

OMIC will present two courses in conjunction with the Joint Commission on Allied Health Personnel in Ophthalmology (JCAHPO): *Delegation of Services to Non-Physicians*, 9:15 to 10 am, and *Refractive Surgery Risk Management*, 11:30 am to noon. Both courses will be held on Saturday, November 15, in the Anaheim Marriott Hotel. Register by calling JCAHPO, (800) 284-3937 or (651) 731-7229. OMIC's 5% risk management discount is not available for attending these JCAHPO courses.

Members Reception

OMIC will host its annual members reception for policyholders and new ophthalmologists on Sunday, November 16, 5:30 to 7:30 pm, in the Coast Anaheim Hotel, Tiffany Terrace and Patio. Please look for your invitation in the mail in October and RSVP by November 6 if you plan to attend.

Proxy Due

Proxies for OMIC's annual members meeting have been mailed to insureds and need to be signed and returned to OMIC as soon as possible. The annual members meeting will be held on Monday, November 17, at 12:45 pm in the Hilton Anaheim Hotel, Room Huntington A.

Annual Renewable Term Life Insurance

By Geri Layne Craddock, CLU, ChFC
Vice President at Marsh Affinity Group Services, a service of Seabury & Smith

There are many products and services available to protect your family. You can install an alarm system to make your home more secure, enroll in a health care plan to ensure your family gets the medical treatment it needs, and purchase auto insurance to cover you and your family while on the road. But financial planning experts agree that one of the most important ways to protect your family and secure their financial stability is with a solid life insurance policy.

Life insurance provides financial protection for your family if you can no longer be there to provide for them. This type of insurance coverage pays cash, also called a *death benefit*, to a designated beneficiary if you die. That money can be used to pay a mortgage, cover daily living expenses, pay down debt, or even fund your children's college tuition. This type of protection not only provides financial security, but also brings peace of mind because it gives your family some breathing room to adjust without having to worry about finances.

Without life insurance, you could leave your family with day-to-day costs as well as bills and debt, and no easy way to pay for them. Financial experts note that in a dual-income household, it's important to have life insurance for both spouses because without the income from one wage earner, most families will struggle financially.

Term Life vs. Whole Life

One popular and widely available type of life insurance is *term life insurance*. Just as its name suggests, term life insurance protects you for a certain term, or length of time. If you die while your policy is in force, your beneficiary will receive a death benefit in the amount of the policy you purchased. If the time period on the policy expires and you're still alive, the coverage ends. Unlike some types of life insurance policies, such as *whole life insurance*, term life insurance policies do not accrue value and cannot be cashed out.

Term life insurance is an excellent way for most people to get the affordable life insurance protection they need. This type of policy is ideal for people who have added financial responsibilities that last for a fixed period of time; for example, young families raising children or couples who have a mortgage. Term life insurance also is a good choice for people who have a limited budget but still want to purchase life insurance coverage.

How Much Coverage Do You Need?

Term life insurance is available in a wide range of coverage levels. As a rule of thumb, you should have life insurance coverage worth five to eight times your annual income.[1] To determine exactly how much you'll need, evaluate your own financial situation. Remember to take into account your assets, liabilities, and the things you want to be able to provide for, such as college tuition for your children.

Many term life insurance plans offer additional benefits or features that provide extra protection for you and your family. For instance, some plans offer an equivalent amount of coverage for your spouse if you enroll. Lower levels of coverage are often available for your children too.

Some plans include a special clause called an *accelerated death benefit*, or *living benefit*. In the event you are diagnosed as being terminally ill, this valuable feature gives you the option to receive a portion of your life insurance benefit while you're still alive. This flexibility gives families much needed cash while they manage the challenges of facing a terminal illness. The money can be used as you see fit: for travel to receive advanced medical care, to hire additional domestic or health care help, or to pay for medical equipment not covered by other insurance plans.

Many Plans to Choose From

Life insurance products are available from many different sources. Shop around for the best coverage, rates, and features. Contact insurance companies, brokers, and associations of which you're a member to find the right plan for you and your family.

The American Academy of Ophthalmology offers a term life insurance plan designed especially for Academy members.[2] The plan provides coverage for members and their spouses at affordable group rates. The plan also features a living benefit that pays up to 50 percent of the life insurance benefit if the member is diagnosed as being terminally ill.

For more information, contact Marsh Affinity Group Services toll-free at (888) 424-2308 or visit the web site at aao.healthinsurance.com.

Notes

1. Insurance Information Institute, www.iii.org.
2. This plan may not be available in all states.

Forensic Consulting: From Immunity to Liability

continued from page 1

shield witnesses from defamation suits filed against them by parties on the opposing side. Sanctions, such as perjury and contempt, were thought to be enough of a deterrent against incompetent, untruthful testimony.

A Tradition of Immunity

American courts followed the English tradition (although some American decisions required a showing that the expert witness statements in question were relevant to the judicial proceeding). Even perjured testimony made in the course of a judicial proceeding could not serve as the basis for a suit in tort. It did not matter if the expert witness was not appointed by the court and received compensation by a party to the action, immunity still applied. Nor was immunity limited to defamation claims. Expert witnesses could not be sued for malpractice, fraud, or libel, either. The cause of action was irrelevant to the application of the privilege.

Over time, however, absolute immunity has been replaced in some jurisdictions by qualified immunity, which only protects expert witnesses from defamation claims brought by opponents of the expert's statements. This may not prove to be much help since defamation actions brought by adverse parties are rare. Instead, parties are increasingly suing their own experts, sometimes called "friendly hired witnesses," on professional negligence or "expert witness malpractice" theories. Even when the witnesses are court appointed, some courts are now allowing cases to proceed against them.

Customarily, courts have found that the public policy of protecting expert witnesses and allowing them to give open and honest testimony without retaliation is so important that even negligence on the part of the expert will not trump his or her immunity from suit. However, the arguments for liability are mounting. Given the significant additional income a physician can earn by offering expert testimony, unscrupulous physicians may be tempted to distort the truth to benefit the party that retained them. The perception is that many experts are not impartial aids to fact finding, but biased advocates for their clients. The threat of liability, it is argued, will encourage experts to be more careful in providing accurate, reliable testimony.

Furthermore, some courts have opined that the safeguards of cross-examination and the threat of perjury prosecution are ineffective at deterring dishonest or negligent testimony because experts today are so experienced at deflecting attacks on their testimony and because it is nearly impossible to convict experts for their faulty reasoning.

The Argument for Liability

Proponents of expert witness liability argue that professional experts (doctors, lawyers, accountants, engineers) should be held accountable for negligence in litigation-related services just as they are in their primary work. Because these experts can choose whom they work for, and charge accordingly, clients should expect that their experts owe them a duty of care. Granting immunity, it can be argued, is contrary to the intent of tort law, which is to compensate an injured party when the cause of the loss can be attributed to someone else and to prevent such future misconduct. The standard of care applied in other professional negligence cases is applicable to that of expert witnesses: Did the expert exercise the care, skill, and proficiency ordinarily exercised by reasonably prudent experts under similar circumstances?

While much of the focus has been on expert witness testimony, because of the continued availability of immunity in some jurisdictions, actual liability may more likely stem from other forensic consulting services. Allegations of misconduct in the forensic exam, review of claims, filing of reports or other extrajudicial practices may allow plaintiffs to get around the immunity protection afforded experts who take the stand.

Furthermore, negligence actions are not the only liability risk for forensic consultants. Unfair competition or fraudulent representation of expertise may be alleged if, for example, the forensic consultant claims to possess degrees or licensure that he or she does not have.

Breach of confidentiality claims against forensic consultants also may stick. For example, a California court found that, in an IME scenario, an evaluator was performing a professional service and thus had a physician-patient relationship with and duty to the evaluatee. As such, it was inappropriate to disclose certain information to the party who arranged and paid for the IME since the disclosure violated state confidentiality laws.

Ethical Guidelines

In addition to legal liability, forensic consultants may be subject to disciplinary action by their professional association ethics board for rendering false reports or giving dishonest testimony, which may result in their suspension or dismissal from the association, or public censure. The American Academy of Ophthalmology may join several other medical specialty organizations in adopting ethical codes or promulgating guidelines for expert witness testimony in medical malpractice litigation. The Academy's Board of Trustees has approved an Ethics Committee request to have the Academy membership vote to add

the following new rule addressing expert witness testimony to the Academy Code of Ethics. If adopted, this rule will go into effect November 2004:

> *Expert testimony should be provided in an objective manner using medical knowledge to form expert medical opinions. Nonmedical factors (such as solicitation of business from attorneys, competition with other physicians, and personal bias unrelated to professional expertise) should not bias testimony. It is unethical for a physician to accept compensation that is contingent upon the outcome of litigation. False, deceptive or misleading expert testimony is unethical.*

The growing trend among medical specialty societies to address the problem of biased and irresponsible testimony by their members has not gone unchallenged. In one well publicized case, a neurosurgeon sued the American Association of Neurological Surgeons (AANS) claiming it unfairly suspended him for testifying against a fellow association member in a malpractice lawsuit. The suspension came after an AANS hearing panel determined that the surgeon had provided "unprofessional testimony" at the trial because the testimony did not have a "convincing basis in either literature or logic."

In his lawsuit, the neurosurgeon argued that the AANS violated state law because it suspended him in revenge for having testified as an expert witness against another AANS member in a medical malpractice suit. He claimed the AANS action deprived him of his due process rights and violated the legal rights afforded members of voluntary associations. He argued that the AANS acted in bad faith because it never disciplines members who testify *on behalf of* malpractice defendants and that it is against public policy for a professional association to discipline a member on the basis of trial testimony unless the testimony is intentionally false.

The district court dismissed his suit – and the 7th Circuit Court of Appeals upheld the lower court's decision – because the neurosurgeon was unable to prove that the association's action substantially impaired an "important economic interest" of his. He continued to practice as a neurosurgeon and still made 35% of his pre-suspension expert witness testimony income. While this was enough to prevent his suit from proceeding, the appellate court also pointed out that, even though all complaints entertained by the AANS had been against plaintiff's experts, this was not evidence of bad faith because, in the course of a malpractice suit, it is generally plaintiff's experts who are going to be critical of another member's care and cause the maligned member to complain.

Professional Self-Regulation or Member Intimidation?

The plaintiff's bar is concerned that medical specialty society codes pertaining to expert witness testimony are an attempt to intimidate members who testify against fellow members. The court in this case disagreed. Because membership in the prestigious society boosts an expert witness' credibility, "the Association had an interest – the community at large had an interest – in (the neurosurgeon's) not being able to use his membership to dazzle judges and juries and deflect the close and skeptical scrutiny that shoddy testimony deserves." Thus, the court opined that professional self-regulation furthers rather than impedes the cause of justice.

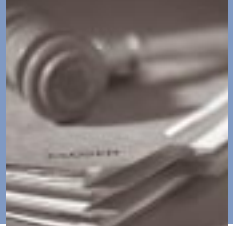
An even greater threat to forensic consultants than voluntary association censure is disciplinary action, including loss of licensure, by the consultant's state licensing board, where witness immunity may not be available to protect the physician.

In order to limit their liability, it is imperative that forensic consultants understand the proper procedures and relevant legal issues and requirements before undertaking such work. Even with the best practices, forensic consultants are never completely immune to liability and should carry insurance that will adequately cover all aspects of their work.

The OMIC professional liability insurance policy covers claims based on forensic consultants' professional services for or on behalf of a formal accreditation, utilization review, or similar professional board or committee of a state licensed health care facility, clinic, or professional society. However, if the insured is hired as an independent consultant or expert witness, the policy only covers claims where an actual (physical) injury is alleged. This would exclude claims by the hiring party in a private lawsuit against the forensic consultant for professional negligence.

To best cover the various risks and liabilities of the full forensic consulting practice, experts in the field suggest that forensic consultants also acquire errors and omissions coverage from a reputable company specializing in this unique exposure.

A list of source references used in preparing this article is available by contacting Kim Wittchow at (800) 562-6642, ext. 653 or kwittchow@omic.com.



Disclosure of Risks, Complications, and Adverse Outcomes

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

Allegation

Loss of vision following cataract surgery.

Disposition

Defense verdict on behalf of insured ophthalmologist.

Case Summary

A 77-year-old female presented to the insured ophthalmologist with complaints of being unable to read, drive, or watch television and vision in the left eye of light and dark sensation only. Visual acuity was 20/25 OD and 20/80 with refraction OS. Past ocular history included peripheral iridectomies OU for intermittent angle closure glaucoma and pseudophakia OD. Medical history was significant for atrial fibrillation treated with aspirin, COPD, and hypertension. The patient had a dense cataract, grade 3-4+. The ophthalmologist recommended phacoemulsification with IOL placement under topical anesthesia and a clear corneal incision. After removing the extremely dense cataract, the insured detected a large rent in the posterior capsule and performed an anterior vitrectomy with removal of the remaining cortex. He attempted to place the IOL in the sulcus but resorted to anterior chamber placement due to instability. No bleeding was noted.

The patient's postoperative course was complicated by the development of a full eight-ball hyphema with loss of vision on day 3; treatment consisted of bed rest in a recliner at 30 degrees and 1% ophthalmic Atropine. The ophthalmologist later testified that he recommended but the patient refused hospitalization; he did not document this or any pre- or postop discussions regarding the possible effects of the patient's aspirin therapy. IOP, slightly elevated at 28 on postop day 1 and treated with topical agents, rose to 62 on day 4 when the patient experienced a rebleed, prompting an anterior chamber paracentesis and hospitalization. An anterior chamber washout was needed the next day to control the pressures. Blood staining of the cornea and IOP of 30 was noted on day 13. The retina specialist to whom the patient was referred performed another anterior chamber paracentesis and found no posterior bleeding on B scan. The patient requested a second opinion; the consultant explained the treatment options but told the patient there was little chance for visual improvement.

Analysis

The plaintiff's expert was critical of the insured on several accounts. First, the insured should have considered the impact of aspirin therapy on the development of the hyphema or rebleed and advised the patient to discontinue taking aspirin once bleeding developed. Second, the insured did not recognize the early readings as falsely low in the face of edema and hyphema. Third, had systemic agents been used to control the patient's elevated pressure, optic nerve damage and the resulting loss of vision might have been prevented. Fourth, the hyphema should have been washed out earlier with care taken to remove the clot.

While noting the insured's lack of documentation regarding aspirin and recommended hospitalization, defense experts supported the accuracy of the IOP measurement and felt he had appropriately recognized and managed the intraoperative and postoperative complications. The jury returned a verdict in favor of the insured ophthalmologist.

Risk Management Principles

The ophthalmologist disclosed the potential complications to the patient and responded each time to the patient's complaints by promptly examining her, even on Christmas. This responsive care no doubt contributed to the jury's defense verdict. Like many patients, the plaintiff was angry about experiencing two rare complications and about learning the permanent nature of her vision loss from a consultant she herself had asked to see. Had the ophthalmologist explained that she had two risk factors that might lead to rupture of the posterior capsule (the dense cataract and the fragile condition of the capsule), the patient might have been better prepared to deal with her poor outcome.

When anticoagulants are medically necessary for surgical patients, the surgeon should explain the need and risks to the patient and choose the most appropriate anesthesia and operative technique. Instructions to stop medications, especially anticoagulants, and recommendations for hospitalization must be documented. When there is significant loss of vision, the patient should be kept informed of treatment options and prognosis for recovery. If a poor outcome is final, the patient should be assisted in adapting to a low vision status.

PAM Testing Before Cataract Surgery

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

A policyholder called OMIC to ask if PAM (Potential Acuity Meter) testing is required before cataract surgery in patients with coexisting eye disease, such as macular degeneration or glaucoma. This question raises important risk management issues about elective surgery. A medical malpractice claim focuses on the following aspects of care: indications for surgery (preoperative evaluation and diagnosis); type of procedure planned (choice of procedure, technique, implant); candidacy for surgery (coexisting ocular and medical conditions, known risk factors for complications and poor outcomes); informed consent (disclosure and documentation of risks, benefits, alternatives); performance of the procedure (technique, recognition, management, disclosure of complications); and postoperative care (discharge condition and instructions, postop visits and telephone calls, recognition and management of complications and poor outcomes). This article focuses on indications and informed consent. The next **Risk Management Hotline** will address risk reduction when performing elective surgery on a patient with serious medical comorbidities.

Q What are the indications for cataract surgery in the adult?

A The American Academy of Ophthalmology's *Preferred Practice Pattern* (PPP), "Cataract in the Adult Eye," states that surgery is indicated if visual function does not meet the patient's need and there is a reasonable likelihood of improvement with surgery. The ophthalmologist would, therefore, need to determine, disclose, and document that the cataract is responsible for the vision loss and verify and document that the cataract-induced vision loss has led to an inability to function.

The PPP points out that patients with ocular comorbidities such as glaucoma or macular degeneration tend to have poorer outcomes after surgery. The ophthalmologist should determine, disclose, and document the impact of cataract-related vision impairment on these preexisting ocular comorbidities in order to carefully manage the patient's expectations about the likely benefits of surgery.

Q Is PAM testing required?

A Some evaluation of potential visual acuity is needed. The PPP discusses various types of subjective (such as PAM) and objective potential acuity tests and concludes that there "is no significant evidence that demonstrates that these tests predict the outcome of cataract surgery more reliably than clinical examination." The actual type of potential acuity evaluation is less important than doing one and informing patients that the predicted results may not match the actual outcome. A PAM may or may not be helpful. Corneal topography, ultrasound, hard lens over refraction, and clinical examination all play an important role, as does evaluation of the patient's distance and near vision, and consideration of such issues as glare.

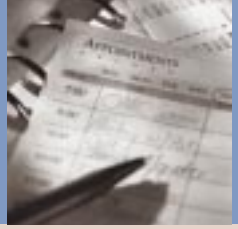
Q How should I handle the discussion if the patient is at high risk for complications or a poor outcome?

A First, *personally* obtain the patient's informed consent. This legal duty cannot be delegated. During the discussion and documentation process, it is crucial to explain the effect of ocular and medical comorbidities and other known risk factors on the likelihood of complications during and after the procedure and on the final outcome. Use a procedure-specific consent form. Circle or underline the appropriate section of the consent and write in the reasons for the increased risk (e.g., hemorrhage if anticoagulants cannot be stopped for medical reasons; rupture of the posterior capsule with dense cataracts). See **Closed Claim Study** on opposite page.

Explain that conditions such as glaucoma, diabetes, and macular degeneration can impact visual acuity and functionality. Inform the patient that while the acuity evaluation indicates that he/she is likely to benefit from surgery, potential acuity testing may not accurately predict the results. Even though you recommend surgery, no guarantee can be made that visual acuity will improve.

Q How can I verify that the patient understands the risks and the likely outcome?

A Patients are understandably anxious and fearful during these discussions and may only hear portions of what you say. Have the patient sign a procedure-specific consent form. Keep the original document in the patient's record and give the patient a copy. Ask the patient to review the document at home with family members and to call your office if there are questions.
Your staff can play a valuable role in verification, either when the form is signed or the surgery is scheduled, by asking patients what procedure will be done and why. If the patient does not appear to understand, you can discuss the procedure again and clear up any confusion. You or your staff can document the repeat discussion and the fact that the patient now understands and consents.



Calendar of Events

OMIC, Medical Risk Management Insurance (MRMI), and Marsh Affinity Group Services will team up at this year's Annual Meeting of the American Academy of Ophthalmology (AAO) to answer questions and provide rate and coverage information on all 15 AAO-sponsored insurance programs available to members. Stop by the Academy/OMIC Insurance Center in Anaheim, located in exhibit hall B, booth 1239, for information on professional liability, business liability, and life, health, and disability insurance.

CME credit and OMIC's risk management 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. OMIC insureds must be a member of the cosponsoring society to earn the special 10% discount.

October

9 *Patient Safety and Professional Liability Risks of Telephone Screening and Care**
Statewide Audioconference
California Academy of Ophthalmology
4–5 pm
Register through OMIC, (800) 562-6642, ext. 652

18 *CODEquest Coding College 2003**
Nevada Ophthalmological Society
8 am–3 pm
Location TBA, Las Vegas, NV
Register through NOS, (303) 832-4900

25 *CODEquest Coding College 2003**
Colorado Society of Eye Physicians & Surgeons
8 am–3 pm
Location TBA, Denver, CO
Register through CSEPS, (303) 832-4900

November

15-18 *Academy/OMIC Insurance Center (Booth 1239)*
AAO Annual Meeting
Anaheim Convention Center, Anaheim, CA

16 *OMIC Mock Litigation*
AAO Annual Meeting
11 am–2 pm
Coast Anaheim Hotel, Anaheim, CA
Register through OMIC, (800) 562-6642, ext. 652

16 *Claims, LASIK, and Lawsuits (AAO Course 256)*
AAO Annual Meeting
3:15–5:30 pm
Hilton Anaheim, Anaheim, CA
Register through AAO, (415) 561-8500

17 *OMIC: Medical Malpractice (AAOE Course 343)*
AAO Annual Meeting
9–10 am
Marriott Hotel, Anaheim, CA
Register through AAOE, (415) 561-8500

December

TBA *Patient Safety and Professional Liability Risks of Telephone Screening and Care**
Statewide Audioconference
Louisiana Ophthalmological Association
Date and Time TBA
Register through OMIC, (800) 562-6642, ext. 652

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

OMIC
Ophthalmic Mutual Insurance Company
(A Risk Retention Group)
655 Beach Street
San Francisco, CA 94109-1336

PO Box 880610
San Francisco, CA 94188-0610

Phone: 800-562-OMIC (6642)
Fax: 415-771-7087
Email: omic@omic.com