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Ophthalmic Risk Management Digest

OMIC DIGEST

What a Difference Two Decades Make

By Lori Baker Schena

Lori Baker Schena is a contributing writer to *EyeNet* magazine. This article is reprinted with the permission of *EyeNet* and the American Academy of Ophthalmology.

This year, the Ophthalmic Mutual Insurance Company (OMIC) celebrates its 20th anniversary. To mark that milestone, *EyeNet* interviewed Joe R. McFarlane Jr., MD, JD, the chairman of OMIC's board, about the changes he has witnessed in the practice of ophthalmology and the field of risk management over the past two decades.

Dr. McFarlane, from a risk management standpoint, how has the practice of ophthalmology changed over the past 20 years?

Changes have occurred in three major areas. First, the way doctors practice has changed. More doctors are practicing as subspecialists, with over 50 percent extending their training into a subspecialty. In addition, 20 years ago most ophthalmologists were in solo practice; today 63 percent are in a group practice.

Second, the arrival of managed care in the early 1990s and its impact on reimbursement have required ophthalmologists to work more efficiently, use more ancillary personnel and, in many cases, start participating in comanagement relationships. Reimbursement has decreased significantly: ophthalmologists today are paid one-fourth to one-third what they were paid for a cataract operation in 1987, despite the fact that the procedure has become more technically difficult.

Third, the availability of new procedures and new drugs that weren't available 20 years ago—from refractive techniques to injections of VEGF inhibitors for neovascular age-related macular degeneration—have helped countless patients, yet each carries certain risks that may open up ophthalmologists to a potential lawsuit.

What were the major issues in liability coverage that faced ophthalmologists in 1987, when OMIC was formed?

There were two main challenges. The first was simply obtaining medical malpractice insurance. In the 1980s, CIGNA had

continued on page 4

MESSAGE FROM THE CHAIRMAN

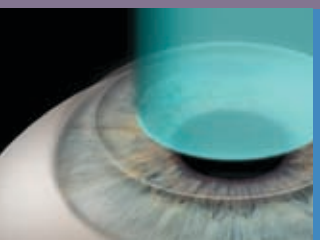
As I look back over OMIC's first two decades and the many changes that have occurred in the practice of ophthalmology since 1987 (see **What a Difference Two Decades Make**), I can't help but wonder what lies ahead for ophthalmology and the insurance industry. Over the next year—my last as OMIC's chairman—I will use this column to share with you what I believe will be the major demographic, economic, and medical-legal issues we will face over the next 20 years.

One thing I know for sure is that the medical profession will continue to be impacted by the cyclical nature of professional liability. For every stable soft insurance market during which physicians are courted by insurance carriers with promises of low premiums, there follows a volatile hard market when many of these same insurers no longer want our business at any price.

It is the nature of soft markets—such as we are now experiencing—that when there is increased profitability and competition among insurance carriers, some companies will engage in predatory pricing to buy business and increase market share. With more carriers competing for our business, ophthalmologists may be tempted to shop for the

continued on page 2

IN THIS ISSUE



Eye on OMIC

OMIC

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

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

Holiday Closure

In recognition of the holiday season, the OMIC office will be working on a dramatically reduced schedule and will respond only to urgent matters the week of December 24 through January 1. If you have an urgent matter and must speak to an OMIC staff member during the holidays, please call (800) 562-6642, ext. 609, and leave a message. Staff will check this message line throughout the week and return urgent calls in a timely manner. Non-urgent messages may be left for specific staff members by calling their usual phone extension. These calls will be returned on Wednesday, January 2, 2008. The OMIC staff wishes you and your family a safe and happy holiday season.

Message from the Chairman

continued from page 1

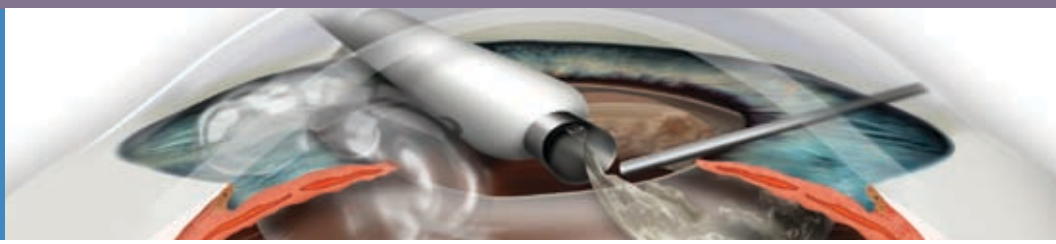
lowest priced coverage. But as we have seen in the past, companies that underprice their coverage in a soft market end up without the necessary reserves to cover their losses or earn a profit in a hard market. When this happens, these underfunded companies have no choice but to raise premiums substantially or exit the market, leaving their policyholders scrambling for replacement coverage, which can be expensive and difficult to find.

This is exactly what occurred during the hard market of 2000-2005 when hundreds of ophthalmologists saw their malpractice premiums skyrocket or were dropped by their insurance carrier altogether. It was then that OMIC's strategy of long-term rate stability and conservative business practices paid off. OMIC was able to ride out those five years of market volatility and remain a stable, reliable, financially sound source of malpractice insurance for members of the American Academy of Ophthalmology. While other carriers faltered, OMIC outperformed many of its competitors in a number of important financial benchmarks and provided a safe harbor for hundreds of ophthalmologists needing coverage.

In the last couple of years, the medical malpractice market has again attracted the interest of commercial carriers seeking short-term profits for their shareholders and investors at the expense of long-term rate stability and coverage availability for their physician-insureds. So, while these newcomers to the market are interested in buying the ophthalmology book of business now, one thing we can all be sure of is that in a few years, when inflation, claims losses, and defense costs have eaten into their profit margin, they will not be courting us anymore.

As premiums rise and underfunded carriers again leave the market, I believe we will see the formation of more specialty-specific risk retention groups, such as OMIC, and other physician-owned malpractice insurance companies to fill the void. Ophthalmologists are fortunate because in OMIC we have the assurance that there is a comprehensive insurance product available to us that is fairly and responsibly priced—now and in the future.

Joe R. McFarlane Jr., MD, JD
OMIC Chairman of the Board



Medical Record Corrections and Alterations

By Kimberly Wittchow, JD, OMIC Staff Attorney, and Anne M. Menke, RN, PhD, OMIC Risk Manager

The medical record serves many purposes: it promotes patient safety and continuity of care by providing a comprehensive account of the patient's diagnosis and treatment, provides evidence that can be used to defend—or possibly assail—the ophthalmologist's care during the course of a claim or lawsuit, serves as the basis for coding and billing decisions, and supports medical research. Entries in the medical record should be objective, signed (or initialed), and dated; subjective comments, speculation, blame, and references to incident reports, legal actions, attorneys, or risk management activities should not, therefore, be included.

Policyholders often learn of the importance of the medical record when they are notified of a claim. Faced with a potential lawsuit, a few are so worried that they are tempted to alter or add to their documentation. While it is never proper to alter records deceptively or fraudulently, there are times when you may need to make a correction or addition to a medical record. OMIC's policy differentiates between these two circumstances to protect you when you make a legitimate change, but also to protect the rest of the policyholders and the company if you make an improper alteration. This article will elaborate on these differences.

Policy Terms

As with all of the terms and conditions of the policy, coverage is contingent upon insureds complying with Section VIII.9.e of the policy, which states that: "The **Insured** must not create, alter, modify, or destroy medical records with the intent to defraud or deceive or otherwise misrepresent or conceal facts pertinent to any **professional services incident** or **Claim**." In other words, records alterations that are not mere corrections are prohibited. Section VIII.9.e continues, however: "This does not preclude coverage where a proper correction or addendum to a medical record has been made, the original entry remains legible, and the correction or addendum is dated and initialed by the Insured."

Corrections to the Medical Record

It is common when documenting care to make "data entry errors." Correcting these errors as soon as possible when they are discovered improves the accuracy of the medical record and promotes safe care. For example, after noting a new medication order he received over the telephone from the ophthalmologist, the technician realized he had written the wrong dosage in the chart. He crossed out the incorrect number once, making sure it was still legible. Over it, he noted the correct one and added his initials and the date.

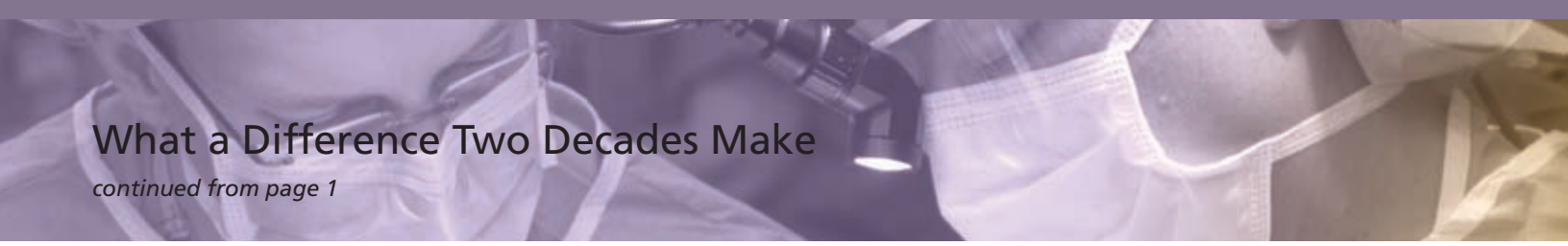
Similarly, dictated reports such as operative notes and consultation letters should be reviewed and corrected as needed before being placed in the medical record or sent to referring physicians. Such corrections should always be related to ongoing care and made with the intention of contributing to that care. The former entry should always remain in the record; as a general rule, information should never be deleted. Corrections removed in time from the event, made after learning of poor outcomes or after receiving notice of a claim, are always subject to scrutiny and viewed as self-serving if not fraudulent, and should be avoided.

Addenda to the Medical Record

An addendum should be created when additional information not available at the time of documentation but necessary for ongoing care is received. For example, a surgeon dictated her operative report, noting the absence of complications during the cataract procedure. Minutes after completing the dictation, the nurse clearing out the instruments informed the surgeon that one of the sterility indicators had not changed, alerting the ophthalmologist that the instruments may not have been properly sterilized. After instructing the nurse to sequester the instruments, the physician met with the patient, explained the situation and the possible increased risk of endophthalmitis if the instruments weren't sterile, advised the patient of symptoms to watch for and report, and later dictated an addendum to the operative report, in which she accurately noted the time sequence of events.

Addenda should begin with an explanation of why one is necessary. Designed to ensure that accurate and timely information is available to properly care for the patient, they should not be used to justify former decisions or actions. Just as with corrections, the timing and motivation behind the addendum will be carefully evaluated in the event of a claim.

When in doubt, contact our **Risk Management Hotline** for advice before correcting or adding to a record.



What a Difference Two Decades Make

continued from page 1

stopped insuring ophthalmologists in Florida, starting a trend where many eye physicians could not obtain a policy . . . period. This was a motivating factor in forming OMIC in 1987.

The second challenge involved the cost of malpractice insurance. Twenty years ago, ophthalmology was considered a low-risk specialty, yet ophthalmologists felt they were being charged too much for malpractice insurance. OMIC was determined to offer less expensive policies.

What are the major issues in liability coverage that face ophthalmologists in 2007?

Affordability of medical malpractice insurance is the number one challenge today. While reimbursement has been relatively flat, office expenses are going up, and medical malpractice costs have increased across the board. Many ophthalmologists are looking for a policy that is affordable but also one that will be there for them as the years go by. Several companies have left the business—St. Paul, for example, in 2001. We think OMIC prices its policies affordably, and we will always be there and excel at what we do.

What changes have occurred in the nature and outcome of ophthalmic malpractice claims over the past 20 years?

The number one claim for ophthalmologists in 1987 is still the number one claim today, and that is cataract surgery. Twenty years ago we thought RK could result in a lot of malpractice claims, but that fear never materialized. However, today, our number two claim involves refractive surgery. These procedures are elective, and usually provide excellent results. However, patients pay for these surgeries themselves, which leads to high expectations. We are also just now learning of some of the long-term complications of refractive surgery, which are being reflected in new allegations and lawsuits. For example, some patients are developing postrefractive ectasia years after the procedure; this condition not only compromises vision, but also may need to be treated with a corneal transplant. Indeed, there have been some multimillion dollar indemnity payments associated with ectasia; while OMIC has had some cases, our losses have been modest in comparison.

Another emerging subspecialty that may generate claims is ophthalmic plastic surgery. These physicians are performing procedures such as facelifts, liposuctions, and face peels with a CO2 laser, which could result in a lawsuit.

New ways of treating glaucoma, with the emphasis on target pressures and visual fields, have resulted in an increase in claims in this area.

Finally, one of the big medical-legal risks in pediatric ophthalmology is the treatment of retinopathy of prematurity, or ROP. These infants may survive but end up blind, and there is a lifetime of potential income that must be paid if an ophthalmologist is found negligent. Since there are so many health care providers involved in the care of premature infants, the possibility of failed communication and getting lost to follow-up is significant. For example, the ophthalmologist could accurately diagnose the infant's condition, determine that the baby needs to be examined again in a week, and then learn upon arrival at the neonatal intensive care unit that the infant was already discharged. If the infant is not seen on schedule and ROP progresses, the family may end up suing the hospital, the neonatologist, and the ophthalmologist. Jury verdicts have been as high as $20 million in non-OMIC cases.

And although we haven't seen this yet, I predict that in the future we will have claims with the multifocal and accommodating IOLs that are being implanted for cataract and refractive purposes. Informed consent is a major component of this surgery, and if it hasn't been given, claims will likely result.

The other procedures that may place ophthalmologists at risk for a lawsuit are intraocular injections of Kenalog for AMD, which have been linked to cataract formation and increased intraocular pressure. These side effects must be taken care of appropriately—otherwise there is the risk of being sued.

What trends are you seeing in ophthalmic claims frequency and severity?

For a number of years, extending from the late 1990s through 2003, claims frequency was increasing to the point where it appeared that one ophthalmologist in six or seven was receiving a written claim for damages. Suddenly, in 2004, the claims frequency decreased to one in 11 or 12, and that trend has continued through 2007. This is great news for ophthalmology.

There are some possible reasons for this. There is speculation about the tort reform measures that a number of states have passed in recent years. Texas, for instance, passed Proposition 12, which changed the state's malpractice environment. Second, the media has been exposing how lawsuits can affect doctors and can increase the cost of care because malpractice policies are becoming more and more expensive. This may serve as a deterrent.

Yet while frequency of claims is decreasing, the severity of the claims that are won has increased, indicating that plaintiff attorneys will concentrate on cases that will bring in the most money. These are cases

where an individual becomes blind in one eye or experiences a bilateral loss of vision. Severity will increase with inflation—individuals will be paid more because wages cost more, and it is more expensive to defend a case because defense attorneys charge more. So there are fewer claims, but the indemnity payments tend to be higher.

One thing we are proud of at OMIC is that our indemnity payments, in comparison to the rest of the industry, are significantly less. We think the reason is that our board of ophthalmologists understands the risks, knows what a case is worth, and knows when to settle a case vs. take it to trial.

What contributions has OMIC made to ophthalmic risk management?

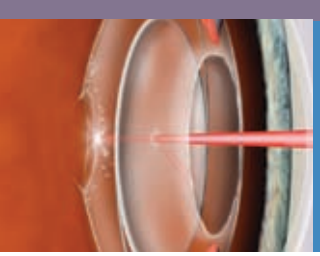
We now insure about 35 percent of those ophthalmologists who are eligible for our insurance, and we set the standard in the industry for ophthalmic risk management. In fact, we make all our documents available for download at www.omic.com to any ophthalmologist who wants them. These documents range from specific risk management recommendations on advertising to comanagement to handling retinopathy of prematurity. We also send out blast emails and other communications when there is breaking news on certain drugs such as Kenalog or Lucentis.

We offer courses at the Academy's Annual Meeting each year, at state and subspecialty meetings, and online through our web site. We want to help our ophthalmologists practice in such a fashion that they are less likely to be sued.

On a final note, I have really enjoyed my association with OMIC. From the beginning, the company has done nothing but work hard for the benefit of ophthalmology in general, and I am proud of OMIC's accomplishments. I am proud of where it is now, and it will be even better in the future.

OMIC'S 10 BIGGEST INDEMNITY PAYMENTS

YEAR OF CARE	YEAR SETTLED	ALLEGATION	PAYMENT
1990	2001	Failure to diagnose glaucoma after cataract surgery in a 3-month-old child, resulting in total loss of vision in the left eye, and impaired vision and extensive cupping in the right eye.	$1,800,000
1994	1999	Failure to diagnose and treat a corneal ulcer in a 2-year-old child after a fall into oily material, resulting in corneal scar and 20/40 visual acuity.	$1,000,000
1996	2002	Failure to obtain informed consent for steroids and monitor for side effects in a 32-year-old patient treated for orbital sarcoidosis, resulting in avascular necrosis of the hip and shoulder.	$1,000,000
1992	1999	Negligent preoperative assessment of a 51-year-old, resulting in cerebrovascular accident following strabismus surgery, leading to total disability and blindness.	$ 999,999
2001	2006	Negligent bilateral LASIK surgery in a 48-year-old, resulting in ectasia and corneal transplant.	$ 983,772
2002	2005	Negligent performance of retrobulbar anesthetic injection for chalazion surgery in a 42-year-old, resulting in central retinal artery occlusion and no light perception vision.	$ 975,000
1997	2001	Failure to follow up on an abnormal preoperative chest x-ray in a 64-year-old patient undergoing cataract surgery, resulting in metastatic lung cancer and death.	$ 850,000
2003	2006	Negligent preoperative clearance, lack of informed consent, and negligent performance of laser facial resurfacing in a 44-year-old with a prior history of Accutane use, resulting in facial disfiguration.	$ 800,000
2005	2007	Negligent resuscitation of a 45-year-old following peribulbar anesthesia and intravenous sedation during a pars plana vitrectomy, resulting in death.	$ 800,000
1989	1993	Misdiagnosis of pterygium and failure to diagnose pituitary tumor in a 41-year-old, resulting in death.	$ 790,000



Closed Claim Study

Conflicting Consent Forms Force A Settlement In Case of Hypopigmentation

By Ryan Bucsi, OMIC Senior Litigation Analyst

ALLEGATION

Facial laser resurfacing performed too soon after Accutane use, lack of informed consent, and alteration of consent forms.

DISPOSITION

The case settled for $800,000.

Case Summary

An OMIC policyholder recommended full facial laser resurfacing on a 45-year-old female patient for treatment of sun damage and facial rhytids. The patient had stopped using Accutane nine months earlier and was counseled during a preoperative visit about the risk of redness and scarring. Since the patient managed the building where the ophthalmologist's office was located, some discussions regarding the procedure took place informally in passing. The patient signed a consent form in the insured's office prior to the procedure; she also signed a consent form at the surgery center on the day of the procedure.

Postoperatively, the patient demonstrated early reepithelialization; however, she was anxious about what she felt was prolonged healing. The patient self-referred to a plastic surgeon, who diagnosed a deep partial-thickness burn over her entire face where the laser surfacing was performed and instructed her to scrub her face and then apply Bacitracin. During a follow-up exam, the ophthalmologist suspected a toxic reaction to the Bacitracin since the patient's skin was sloughing off. He debrided the skin, encouraged the patient to follow his instructions only, and informed her that she was now at a higher risk for scarring, delayed healing, and retraction. Poor epithelialization continued. Despite the ophthalmologist's warning, the patient continued to consult with dermatologists and plastic surgeons, one of whom opined that the patient's use of Accutane nine months prior to facial laser resurfacing had resulted in fewer sebaceous glands and contributed to slower wound healing. At this point, the patient stopped treatment with the OMIC insured and filed a lawsuit, during which she produced evidence of severe, irreversible hypopigmentation.

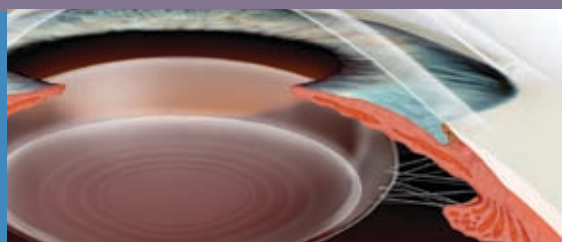
Analysis

The plaintiff alleged that the ophthalmologist should have waited longer post-Accutane use to perform the facial laser resurfacing. If this had been the only allegation, it is quite possible that the insured's care could have been successfully defended at trial. Unfortunately, the primary issue in this case shifted to informed consent upon the plaintiff attorney's discovery of two separate consent forms on which different risks had been circled from the same list of complications and different additional risks had been handwritten in by the ophthalmologist. The insured's explanation of how this occurred seemed plausible: he took his office chart copy of the form with the patient's name, procedure, signature, and date to the surgery center and used it during the discussion he had again with the patient that day. Following the procedure, the surgery center approached him and asked him to fill out the center's copy of the consent form, which he did without consulting the copy that was in his records. The plaintiff attorney alleged that the insured wrote in the risk of severe hypopigmentation after the patient's difficulties began in postoperative recovery and then falsely entered the date. These allegations of fraudulent alteration would have been difficult to defend and could have exposed the insured to a verdict exceeding his policy limits. For these reasons, the insured requested that OMIC settle the case on his behalf.

Risk Management Principles

Whether treating employees, business acquaintances, or friends, physicians should follow normal office protocols for conducting preoperative assessments, obtaining informed consent, and monitoring the patient postoperatively. Document all discussions with a patient, even if they occur outside the office setting or by telephone. It is not sufficient to simply document that a consent discussion took place. The specific risks and complications discussed with the patient should be noted, dated, and signed. Particular attention should be paid to documenting complications for which the patient is at increased risk (e.g., your prior use of Accutane puts you at higher risk for delayed healing). Ideally, the patient should sign a procedure-specific consent form in the physician's office and be given a copy to review at home. Rather than fill out two forms, physicians should provide the hospital or surgery center with a copy of their signed office consent form as proof that the legal duty of obtaining informed consent has been fulfilled.

Risk Management Hotline



Medical Record Requests

By Hans Bruhn, MHS
OMIC Senior Risk Management Specialist

Medical record requests (MRR) are made for various business reasons (e.g., billing matters) as well as for ongoing patient care (e.g., referral to another physician or specialist). These requests require written authorization from the patient. The only exceptions to this rule involve requests pursuant to subpoenas, search warrants, or court orders, and certain mandatory reporting obligations where the law expressly allows for disclosure within the physician's discretion.

Sometimes, an MRR is the first indication that a patient is dissatisfied with the treatment rendered and intends to file a lawsuit. This issue's **Closed Claim Study** demonstrates that the medical record is an important defense against allegations of improper consent or poor overall management of care and underscores the need to respond carefully to an MRR.

Q My practice regularly receives requests for medical records from various parties (patients, attorneys, etc.). Do I have to release the patient's records to anyone he or she designates?

A Yes, but each request for medical information should be evaluated carefully. Federal and state laws and regulations clearly specify that patients have the right to decide who has access to their medical information. HIPAA is the primary source for federal regulations on access to medical information and your state medical society can provide you with state requirements. Physicians should only release a patient's medical information upon receipt of written authorization from the patient or the patient's legal representative. The written request should meet HIPAA standards. (See www.omic.com for a sample medical record authorization.)

Q Should I designate a specific person in my practice to respond to these requests?

A Yes, in order to ensure that an MRR is handled properly, only authorized staff members in a physician's practice should handle these requests. A written procedure should be developed for the practice and reviewed regularly with staff so it is clear who is authorized to handle these information requests. Be sure that these designated staff members are familiar with access laws and regulations as well as what can or cannot be done in the process of preparing a file for release to another party. For example, no "clarifying" remarks or statements should be added to the records prior to release. While these comments may be well intentioned, they will invariably furnish plaintiff attorneys with an opportunity to question the motive, and potentially damage the defensibility of your care. Of course, alteration of records is illegal and should never be done.

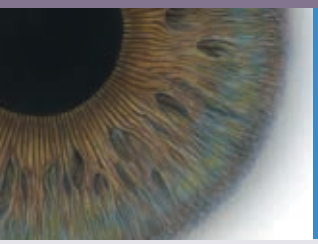
If you feel that clarifying statements are needed, a separate file should be created. This is the appropriate place for statements clarifying chart entries, elaborations on your customs and practices for treatment, and recollections of your decision-making process. If a formal claim is made, your defense attorney may find this information helpful.

Q Can I release the "original" medical record?

A While a patient is given authority to control access to his or her medical information, the physician or surgical facility retains ownership of the record. Therefore, a physician should never release original records to a patient, a patient's representative, or any other third party. Copies or a summary of treatment should be provided instead. Original medical records should only be released in appropriate instances (e.g., valid search warrant, court order, or subpoena). Contact OMIC's **Risk Management Hotline** at (800) 562-6642, ext. 651 or 662, if you are unsure whether original documents or copies should be released, or if you have other questions related to record releases.

Q Do I need to release records we have received from other physicians? How about letters from the patient and billing records?

A Yes, anything related to patient care and treatment is considered part of the medical record, and should be released unless the authorization specifies more limited information. For additional information on confidentiality, see "Confidentiality/ Privacy Issues and Malpractice Claims" in the **Risk Management Recommendations** section of www.omic.com.



Calendar of Events

OMIC will continue its popular risk management programs in 2008. Upon completion of an OMIC online course, CD recording, or live seminar, OMIC insureds receive one risk management premium discount per premium year to be applied upon renewal. For most programs, a 5% risk management discount is available; however, insureds who are members of a cooperative venture society may earn an additional discount by attending a qualifying live cosponsored event or completing a state society or subspecialty society course online (indicated by an asterisk). Courses are listed below and on the OMIC web site, www.omic.com. CME credit is available for some courses. Please go to the AAO web site, www.aao.org, to obtain a CME certificate.

Online Courses *(No charge for OMIC insureds)*

- *Documentation of Ophthalmic Care*
- *EMTALA and ER-Call Liability*
- *Informed Consent for Ophthalmologists*
- *Ophthalmic Anesthesia Liability*
- *Responding to Unanticipated Outcomes*

State and Subspecialty Society Online Courses

A society-specific online course on *Documentation of Ophthalmic Care** is available for physicians in California, Colorado, Hawaii, Iowa, Louisiana, Missouri, Nevada, Oklahoma, Washington, the American Society of Plastic and Reconstructive Surgeons (ASOPRS), and Women in Ophthalmology (WIO). Contact Linda Nakamura in OMIC's Risk Management Department to register for these online courses.

CD Recordings *(No charge for OMIC insureds)*

- *After-Hours and Emergency Room Calls (2006)*
- **NEW!** *Lessons Learned from Settlements and Trials of 2006.* Subjects include claims resulting from a "wrong" IOL, hemorrhage during blepharoplasty, and dry eye following co-managed LASIK surgery. Free to OMIC insureds; $60 for non-OMIC insureds.
- *Lessons Learned from Trials and Settlements of 2005.* Subjects include follow-up on high-risk postoperative patients, minimizing failure to diagnose allegations with focus on giant cell arteritis, and monitoring patients on steroids for ongoing need, effectiveness, safety, and compliance.
- *Lessons Learned from Trials and Settlements of 2004.* Subjects include informed consent for cataract surgery, traumatic eye injuries, and ASC: anesthesia provider, monitoring, discharge.
- *Noncompliance and Follow-Up Issues (2005)*
- *Research and Clinical Trials (2004)*
- *Responding to Unanticipated Outcomes (2004)*

Go to the OMIC web site to download order forms at www.omic.com/resources/risk_man/seminars.cfm.

Upcoming Seminars

January

15 *Now What Do I Do?**
Washington DC Metropolitan Ophthalmological Society (WDCMOS)
Location: TBA
Time: TBA
Register by calling (301) 787-6607 or email at info@wdcmos.org

23 *Documentation of Ophthalmic Care**
Hawaiian Eye 2008
Hilton Waikoloa Village, Waikoloa, HI
Time: 2–4 pm
Register by calling (888) 960-0256 or http://www.vindicome-ded.com/meetings/OSN/hawaii08/default.asp

26 *Now What Do I Do?**
Ohio Ophthalmological Society (OOS)
Hilton at Easton Town Center, Columbus, OH
Time: TBA
Register with OOS at (614) 527-6799 or email oos@ohioeye.org

February

28 *Contemporary Issues in Ethics and Law**
New England Ophthalmological Society (NEOS)
John Hancock Hall, Boston, MA
Time: 1–4 pm
Register with NEOS at (617) 227-6484

March

1 *Now What Do I Do?**
Illinois Association of Ophthalmology (IAO)
Rosemont, IL
Time: TBA
Register with the IAO at (847) 680-1666 or email EyeOrg@aol.com

For further information about OMIC's risk management programs, or to register for online courses, please contact Linda Nakamura at (800) 562-6642, ext. 652, or via email at lnakamura@omic.com.

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