

# OMIC DIGEST

## Misunderstanding Common in Consent Discussions

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

Informed consent laws in most states require physicians to advise patients of their condition, the proposed treatment, and the risks, benefits, and alternatives of the procedure, including no treatment. The standard of what to disclose is usually what a “reasonable layperson” would want to know before agreeing to undergo surgery. The plaintiff in a lawsuit for lack of informed consent needs to prove that he would have refused to consent if the surgeon had advised him of a risk he considered “material” to his decision-making process. As the following claim shows, ophthalmologists and patients may have very different understandings of what information is needed.

It was not surprising that a patient who suffered intraoperative complications filed a lawsuit after

undergoing four additional surgeries. The claims made in the lawsuit were fairly common ones for ophthalmic surgery. The plaintiff alleged that the cataract procedure was not necessary, that his physician did not obtain his informed consent, and that the intra- and postoperative complications were poorly managed. The initial defense evaluation supported the physician’s care. The prior medical records refuted the allegation of unnecessary surgery, as they chronicled slowly worsening vision that was no longer corrected by glasses or contact lenses, culminating in a referral to the defendant ophthalmologist for cataract surgery. Challenging the claim of lack of informed consent seemed similarly straightforward: the eye surgeon had documented a discussion of risks and benefits, and

the plaintiff had signed a detailed, procedure-specific consent form in the physician’s office as well as a surgery center form that briefly listed risks that included blindness. Finally, expert witnesses supported the ophthalmologist’s management of the initial complication—*intraoperative floppy iris syndrome*, which at the time of the surgery did not even have a name yet—as well as its sequelae (rupture of the posterior capsule, iris defect, glare, and retinal detachment).

As the investigation of the suit proceeded, the lack of informed consent allegation became central, and information emerged that helps illustrate the problem some patients encounter during consent discussions. The plaintiff acknowledged in his deposition and in court that he had, indeed, read and signed the cataract consent form. Nonetheless, he insisted that the crucial piece of information that formed the basis of his decision to agree to surgery was not in the form itself. It was instead the ophthalmologist’s response to questions about the rate of complications that “there’s hardly anything we can’t fix.” The plaintiff maintained, again and again,

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### Message from the Chair

“Extra! Extra! Read all about it.”

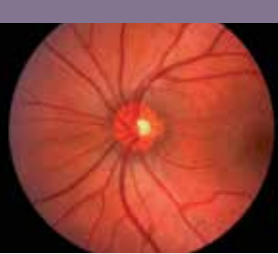
This issue of the *Digest* may have some of the most practical information you’ll ever find on arguably the greatest global risk management issue in medicine: informed consent. When not managed properly, informed consent deficiencies can create trouble and misery for patients and physicians alike. A recent review of our own claims shows allegations of improper

informed consent are over 50% more likely to result in a plaintiff award with damages that are substantially higher as well. Why is informed consent so critical? When we don’t take the time to properly educate patients about the pros, cons, and alternative options of the medical treatments we provide, we open ourselves to claims that they would have refused treatment had they been adequately apprised of the risks.

When things go wrong, there are two groups of patients who are more likely to allege improper consent: those who tend not to question the recommendations of their doctors and those who have strong—and

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# Eye on OMIC



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## What You Should Know about Rates and Dividends

**T**he Board of Directors is pleased to announce a 25% dividend for all physician insureds in the form of a 2015 renewal premium credit and continuation of 2014 rates through your 2015 policy year. Issuance of the dividend requires that an active 2014 professional liability policy be renewed and maintained throughout the 2015 policy period. Mid-term cancellation would result in a pro-rata dividend.

Dividends appear on your policy invoice as a credit to either your annual or quarterly billing installment. OMIC issues dividends as a credit toward renewal premiums for two reasons. First, premium credits offer favorable tax implications for policyholders. Second, premium credits allow for easy and efficient distribution of dividends.

Each year OMIC's Board receives a report from actuaries describing current claims trends and how they relate to rate levels for each state and territory. Using this information, we determine whether a rate increase or decrease for the current

or upcoming year is warranted. Dividends, on the other hand, are generally determined on the basis of whether claims trends for past years are better (or worse) than expected. Because malpractice claims have a "long tail," in which resolution often occurs several years after the incident is reported, trends are only evident after careful monitoring of claims over a significant period of time.

OMIC continues to reduce malpractice insurance costs through lower rates and paid dividends. In addition to average premium reductions of nearly 30% nationally since 2005, OMIC has announced dividend credits totaling more than \$58 million since our company's inception, outperforming our peer companies by a significant margin. Issuance of dividend credits is not guaranteed and is determined each year after careful analysis of our operating performance. OMIC's philosophy is to return any premium above which is necessary to prudently operate the company and to do so at the earliest opportunity.

### Message from the Chair

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potentially unrealistic—expectations for their clinical outcome. These are people who may have low health literacy (not to be confused with IQ) and need more explanation and education on the potential consequences of any medical intervention. In these situations, it is especially important that informed consent and patient instruction are not just thorough but meticulously documented. While it is neither possible nor practical to list every conceivable risk, the most common and the most catastrophic potential adverse events are a good place to start. Forms that use plain English and emphasize the active voice are most understandable, e.g., "Take your drops twice a day," versus "Topical medications should be used twice daily." Note in the record what patient education materials were given out. These resources serve as "extenders" of your informed consent discussion. Keep copies of these handouts as they will be powerful evidence in our defense of you should you be sued.

Feeling overwhelmed? We are here to help. OMIC has scores of procedure-specific consent

forms—downloadable and customizable—that are now, through a partnership with the Academy's Foundation, also translated into Spanish. Just a click away at [www.omic.com](http://www.omic.com), these forms combine frank discussions on risks/benefits/alternatives with disease-specific patient education to help arm patients with information they need to feel confident in their medical decision-making. Also on the website is an informed consent webinar, "My Doctor Never Told Me THAT Could Happen." We feel so strongly that proper informed consent will strengthen our defense of any litigation that we will give ophthalmologists a 5% to 10% premium credit just for viewing it. Looking for more patient education materials to supplement your practice? Check out the new and innovative multimedia offerings on the [aao.org](http://aao.org) website.

Informed consent is part of the conversation that we have with our patients. It acknowledges the vagaries inherent in medicine and fosters a climate of candor, rapport, and trust that may very well represent the best weapon we have against litigation: a meaningful personal connection with the patients we treat.

Happy reading.

**Tamara R. Fountain, MD, Chair of the Board**



## Online Renewal Applications

Betsy Kelley, OMIC Vice President, Product Management

**A**s part of OMIC's continuous underwriting process and to ensure that the policy accurately reflects the insured's current practice activities and liability exposures, insureds are asked to complete a renewal questionnaire each year. We are pleased to announce that you now have the option of completing your renewal applications online. This feature is available for all insureds renewing on or after May 1, 2015, and applies to physicians, employed optometrists and nurse anesthetists, entities, medical spas, outpatient surgical facilities, and eye banks.

You may elect to receive your application electronically or receive a paper application by mail. If you do not designate a preference, you will receive both an electronic and paper application. (However, you will need to complete only one version of the application. For example, if you complete the electronic application, discard the paper version.)

In a November e-bulletin announcing this new feature, insureds were given an opportunity to indicate their preference. If you did not receive this communication or did not respond at that time and would like to designate your preference now, please email [eapp@omic.com](mailto:eapp@omic.com) or call your underwriter at 800.562.6642, ext. 639. Please provide your full name, policy number, and preferred email address when indicating your preference. You may change your preference at any time.

It may be necessary to adjust the settings on your spam filter so that emails from [eapp@omic.com](mailto:eapp@omic.com) are not blocked.

### Registration required

To complete an online application, you must be registered on OMIC's website, [www.omic.com](http://www.omic.com). If you have already registered on MyOMIC to access Policyholder Services or other secure areas of OMIC's website, your existing user name and password will provide you access to your electronic application. A temporary user name and password will be assigned to you if are not yet registered. Each insured (e.g., the owner-ophthalmologist and the sole shareholder corporation) must have a unique login.

### Accessing your application

When your renewal application has been created and is ready for completion, you will receive an email from [eapp@omic.com](mailto:eapp@omic.com) providing a link to your application. If multiple insureds within the practice share the same email address (for example, the practice administrator's email address), a separate email will be sent for each insured. The subject line and salutation will indicate the name of the insured to whom the application applies.

After you log in, you will be taken to a worklist where your pending application(s) is waiting. Click "Edit Application" to access and fill out the selected form. The electronic application will include all supplemental questionnaires (if any) applicable to you. Sections may appear or disappear depending upon your responses to the questions. The applications are dynamic, so you will be asked to complete only those questions pertinent to you.

While completing your application, you may be asked to upload certain documents. File

formats acceptable for upload include Word, RTF, PDF, TXT, TIF, JPG, and BMP. If a file upload is required and you do not have the document readily available in a permitted format, you may attach a Word document explaining why the document cannot be attached and indicating when and how the document will be forwarded to OMIC.

You may save an incomplete application and return to it at a later date by logging in to OMIC's website, [www.omic.com](http://www.omic.com), and clicking "Finish or View My Application" under "My Applications" on the MyOMIC page. Login is required to access this site.

### Submitting your completed application

It is permissible for the employer or practice administrator to assist with the renewal application process. However, the insured must personally review and electronically sign the application before submitting it. To facilitate this, there is a "notify" button on the worklist that provides the user the ability to notify another person via email that the application is ready for that person to fill out.

After you submit your electronic application, you will receive an email notifying you that OMIC has received your application. Your completed application will also be available online as a PDF and may be printed or saved as needed.

If you have any questions regarding this new feature or require assistance completing your online application, please contact your underwriting representative at 800.562.6642, ext. 639.



# Misunderstanding Common in Consent Discussions

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that without such reassurance, he would not have consented to the surgery and without the surgery, he would not have suffered harm. The ophthalmologist adamantly denied making any such statement. He remembered instead that the plaintiff wanted to have a sense of the frequency of complications and that he gave him an estimate of the more common ones. The plaintiff refused to dismiss the suit and the surgeon refused to settle, so the case proceeded to a jury trial. The trial monitor felt that the key moment came when the defense attorney elicited an admission from the plaintiff that just three months before his surgery, he had served as the attorney in a lawsuit against another ophthalmologist for lack of informed consent for cataract surgery, a role that required him to have extensive knowledge of the risks of that procedure. The jury returned a defense verdict after only an hour of deliberation.

## Why don't patients understand risk information?

It is tempting to dismiss this malpractice claim as yet another example of a frivolous lawsuit. While the defense verdict was appropriate, there are important lessons to be learned from this claim. First, the plaintiff no doubt suffered while dealing with the complications and five surgeries, despite his final uncorrected visual outcome of 20/30. Many patients who experience complications conclude that the surgeon must have done something wrong, and ophthalmologists would be well-advised to proactively address this issue with such patients. An even more compelling interpretation comes from the field of "health literacy." While the plaintiff was an intelligent and experienced litigator, when seated across from the surgeon during the consent discussion, he was simply a patient whose fears may have

impaired his ability to listen, reason, and make decisions. According to the National Patient Safety Foundation (NPSF), "health literacy—the ability to read, understand, and act on health information—is an emerging public health issue that affects all ages, races, and income levels."<sup>1</sup> The NPSF asserts that the health of some 90 million people in the United States may be at risk because of such difficulties. Studies of this issue show that most patients, even those like this plaintiff with a high literacy level, struggle to understand healthcare information and that those with limited reading skills or difficulty understanding mathematical concepts are particularly challenged. Low health literacy appears to be at the root of noncompliance and many medication errors and leads to higher healthcare costs and poorer outcomes. A review of the last five years of closed malpractice claims suggests it may also be a driving force in lawsuits alleging lack of informed consent. This issue of the *Digest* will present the results of this study of OMIC claims and make recommendations for improving patients' ability to fully engage in the informed consent process.

## Analysis of informed consent claims

Malpractice claims regularly challenge the adequacy of the consent process. To determine the frequency of these claims and the forces behind them, lawsuits and claims that closed

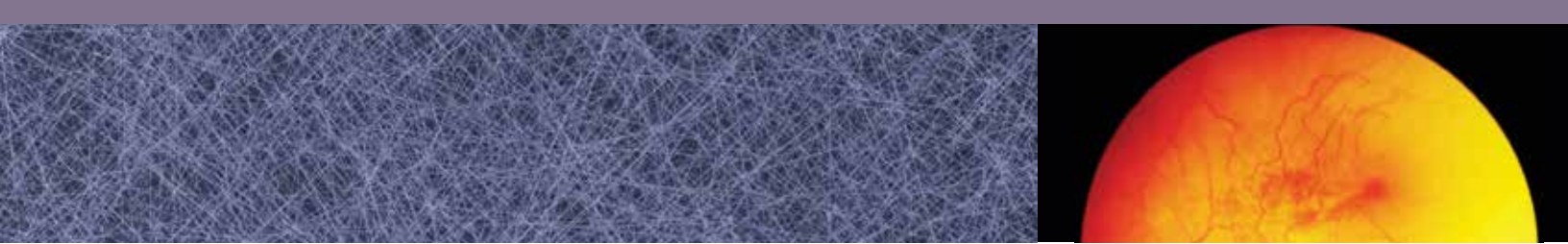
between January 1, 2009, and August 31, 2014, were reviewed. They were classified as "informed consent claims" if the criticism about consent formed an important part of the plaintiff's case, even if this was not the sole or primary allegation. This contention was found in 54 of the 1305, or 4%, of the reviewed claims. Two claims resulted in plaintiff verdicts and 16 others were settled by OMIC. Defendant ophthalmologists were awarded defense verdicts or granted motions for summary judgment by the courts four times, while 32 others were dismissed by the plaintiff without any payment by OMIC. The table below gives details on the amounts paid to settle these claims and compares them to OMIC claims overall. Informed consent claims were more successful for plaintiffs than claims overall during the same time period, requiring a payment to resolve them in 33% versus 20% of claims. Moreover, the mean and median payment were both higher for informed consent claims. The most useful part of the claims analysis, however, is the information it provides on the two types of situations most likely to lead to miscommunication about risk.

## Vulnerable patients who accept recommended care

All patients undergoing surgery are at risk for common complications such as infection, hemorrhage, loss of vision, and damage to the eye. Patients with complex histories, or

### Payments for Informed Consent Claims vs All OMIC Claims

TYPE	INFORMED CONSENT CLAIMS	ALL OMIC CLAIMS
Percent paid	33%	20%
Mean (average value)	\$227,106	\$202,980
Median (middle value)	\$200,000	\$125,000
Range	\$5,000 to \$1,000,000	\$1,650 to \$2,000,000



those with comorbid eye or systemic conditions, are often at higher risk. And many of these patients are elderly and non-English speaking, which can increase the obstacles to successful communication as the studies on low health literacy show. The following claims illustrate that plaintiff and defense experts alike criticized insureds for their failure to address additional risk in such patients.

An elderly patient with a history of several surgeries for a pituitary tumor and an increasing cup-to-disc ratio and pale optic nerve presented with a macular hole. The ophthalmologist recommended a vitrectomy. Postoperatively, the patient sustained significant vision loss whose cause was never determined. In his lawsuit for negligence and lack of informed consent, the plaintiff claimed the ophthalmologist assured him that his vision would improve and did not discuss any risks. Moreover, the eye surgeon asked him to sign a generic consent form that listed the type of surgery but did not specify risks either. The plaintiff expert strongly criticized the defendant ophthalmologist for not explaining how the preexisting damage to the optic nerve would exacerbate the effect of any further loss of vision. Defense experts supported the decision to perform surgery but acknowledged that if the plaintiff's account of the discussion were to be believed, his informed consent had not been obtained. Defense counsel found the plaintiff and his wife to be sympathetic and credible, so the physician agreed with the defense attorney's advice to settle the case for \$250,000.

Another elderly, frail patient who suffered corneal decompensation after a combined cataract and glaucoma surgery testified in her deposition that the physician never told her what procedure he would be doing and never informed her that

she had a cataract. She was unable to state, even at her deposition, what surgery had been performed. Plaintiff and defense experts agreed it was not clear that the patient had understood that she was consenting to a combined procedure, much less how having two done at the same time impacted the risk profile of the surgery. Her claim settled with the physician's consent for \$140,000.

A third patient who did not speak or read English did not realize that the consent form he signed was an agreement to participate in clinical research instead of for cataract surgery. When he suffered a series of complications, including capsular tear, a dislocated IOL, and a giant retinal tear, and ended up with NLP vision, he sued. The plaintiff alleged not only lack of informed consent but fraud about the clinical trial. The patient was never enrolled in research and had merely been given the wrong form. The defense was unable to get the fraud allegation and demand for punitive damages dismissed, so the physician agreed to settle the case for \$200,000. The informed consent process in these claims was far from ideal. Each time, the patient accepted the information or document provided by the ophthalmologist and followed the recommendation to have surgery without asking questions or raising concerns.

### Patients with strong preferences

Unlike the vulnerable patients described above, some patients are clearly engaged in the consent discussion, ask questions, and state their preferences. When those wishes seem to be ignored, they sue. One patient, for example, did not want to wear glasses after cataract surgery and affirmed this goal at each preoperative visit. She took home the procedure-specific consent form to review again. When she

read that glasses were often needed after cataract surgery, she called the surgeon, changed the form to cross out that section, and mailed it back to the office. Postoperatively, she not only needed glasses but experienced pain. Efforts to ascertain the cause were in vain, but her vision improved and the pain disappeared after an IOL exchange was performed by another ophthalmologist. The plaintiff expert's only criticism related to informed consent. Feeling his care was appropriate, the physician refused to settle. During discussions after they had rendered their verdict, members of the jury opined that the surgeon should have noted and addressed the changes to the consent form and that the plaintiff did not get the outcome she wanted. They awarded her \$12,916, which covered the cost of the two procedures, and \$4,200 for her pain and suffering.

Three additional lawsuits stemmed from a misunderstanding about the need for glasses after cataract or refractive surgery. Four others challenged the consent for monovision. Patients seem to better hear and remember comments that appear to promise benefits. These eight lawsuits show that ophthalmologists need to not only explain risks, but also clarify surgical goals and manage expectations. Eye surgeons should consider postponing or cancelling surgery on patients who are not willing to accept the need for glasses or the possibility of complications. This review of informed consent lawsuits shows that patients who consent to surgery may not understand what they have been told. The *Hotline* article will explore ways to confirm that key information has been effectively communicated.

1. National Patient Safety Foundation. Health Literacy: Statistics at a Glance. [http://c.ymcdn.com/sites/www.npsf.org/resource/collection/9220B314-9666-40DA-89DA-9F46357530F1/AskMe3\\_Stats\\_English.pdf](http://c.ymcdn.com/sites/www.npsf.org/resource/collection/9220B314-9666-40DA-89DA-9F46357530F1/AskMe3_Stats_English.pdf). Accessed 11/5/14.



# Closed Claim Study



## Allegation

Failure to provide informed consent regarding risk of complications from PRK OS with forme fruste keratoconus.

## Disposition

Case settled for \$200,000.

## FFK Diagnosed on Day of Planned Bilateral LASIK

Ryan Bucsi, OMIC Senior Litigation Analyst

### Case summary

**A** 30-year-old female presented to an OMIC insured's office for a LASIK evaluation. The initial consultation was handled by a technician, who discussed risks such as dry eyes, fluctuation in vision, light sensitivity, and glare with the patient. Upon examination, the insured noted SCVA of 20/800 OU and CCVA of 20/20 OD and 20/30 OS. The corneal examination revealed a pachymetry of 520 in each eye with a decreased tear film OU. The insured's diagnosis was myopia and tear film insufficiency. The patient agreed to undergo bilateral simultaneous LASIK. Approximately two weeks later, when the patient presented for surgery, the insured diagnosed forme fruste keratoconus (FFK) OS based on the color topography. The patient signed consent forms for LASIK and PRK, and the insured performed LASIK OD and PRK OS. The postoperative course was unremarkable in the right eye; however, the patient complained of poor visual acuity, blurry vision, halos, light sensitivity, and headache in the left eye. Visual acuity fluctuated between SCVA 20/200-20/800 OS with CCVA 20/70 OS. The insured treated the patient's complaints with Pred Forte and oral Prednisolone. After several months with no improvement, the patient requested and the insured provided a referral for a second opinion. The second opinion was central haze and inferior steepening on topography post PRK. Visual acuity was SCVA 20/200 pinholed to 20/30 OS. The patient was advised by the second ophthalmologist to continue Pred Forte and was fitted with a rigid gas permeable contact lens (RGPCL). The patient returned to the insured, who documented CCVA of 20/30 OS with the RGPCL; however, the patient could not tolerate the lens and a soft contact lens did not improve her vision. The insured noted SCVA of 20/400 OS. The patient self-referred to a third ophthalmologist, who diagnosed inferior steepening and mild corneal haze OS following PRK with FFK. CCVA was 20/80 OS. The third ophthalmologist recommended that the patient continue with the RGPCL. During the insured's final exam, the

SCVA was 20/20+1 OD and 20/400 OS, with CCVA of 20/60 OS. The insured's diagnostic impressions were corneal haze and FFK OS.

### Analysis

A dispute existed between the insured and the patient regarding the informed consent process. The insured informed our defense counsel that he fully discussed the risks of PRK with the patient due to the diagnosis of FFK on the day of surgery. The insured handwritten in the chart that he discussed this with the patient. The patient testified at her deposition that she did not recall the insured having any discussion with her about the risks, benefits, and alternatives to PRK with the diagnosis of FFK. Defense experts retained by OMIC felt that, even though the more conservative PRK procedure was performed on the left eye, the patient deserved more information regarding the specific higher risks she faced postoperatively due to the FFK. Defense counsel estimated a defense verdict chance of 50% with a plaintiff verdict as high as \$500,000. With the insured's consent, the case was settled for \$200,000.

### Risk management principles

It is important to review key studies like topography before the day of surgery. Even though the ophthalmologist correctly revised the surgical plan from bilateral simultaneous LASIK to LASIK OD and PRK OS, there was no urgency to perform either procedure the same day the FFK OS diagnosis was made. Due to the increased risk of complications following PRK on an eye with FFK, surgery could have been postponed to give the patient more time to reconsider whether to proceed with what are both elective procedures in light of this new information. Since the decision was made not to postpone surgery, the insured should have expanded his handwritten note to include a more thorough description of exactly which risks, benefits, and alternatives were discussed with the patient. Furthermore, a notation should have been made that the patient understood the new diagnosis along with the associated increased risks and still wished to proceed with surgery.





## Plain Language Concepts in Consent Discussions

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

**T**he analysis of informed consent claims presented in the lead article indicates that patients often don't understand the planned surgery. How can busy eye surgeons and their staff better explain the risks of treatment while staying on schedule? How can they know which patients need additional guidance or have misinterpreted what they have been told? Health literacy experts suggest that the use of "plain language" can help. This article will introduce this idea and explore ways it may be used to communicate more effectively. It will also discuss why changes to the informed consent process need to be made with care.

**Q** What exactly is "plain language"?

**A** The term is often used to measure the understandability of written material but applies to speaking as well. A document written in plain language allows people to find what they need, understand what they find, and act appropriately on that understanding.<sup>1</sup>

**Q** Are there guidelines for speaking and writing in plain language?

**A** Yes, there are a number of key principles, such as organizing material so the most important behavioral or action points come first and breaking complex information into understandable portions with one idea per sentence. One simple change you can make to enhance the clarity of messages is to use the active voice to make clear what action needs to be taken and by whom. Instead of "The drops should be used twice a day," say "You need to put the drops into your eye twice a day." Another tool is to use lists to make points: "You need

to use three different eye drops after your surgery. The first one with the green label treats infection...." Employ "living room" words that patients already know to explain medical terms and include examples and analogies. For instance, "Eyes are usually round like a basketball. Yours is shaped like a football. This shape makes your vision blurry and is called astigmatism."

**Q** I appreciate that anxious patients may have a hard time understanding the information I present. What else can I do to help?

**A** Start by stating the purpose of important parts of your discussion. "We know you have a cataract and that it needs to be removed. Now I need to decide what type of intraocular lens to put in your eye. To do that, I need to ask you some questions about how you use your eyes and what your goal is for the surgery." Clarifying the key point is especially helpful for patients with complex conditions or those at higher risk. "You need this surgery to treat the hole in your retina. But your vision is already limited. I want to explain how the normal risks of this operation could cause extra problems for you."

**Q** How can my staff and I tell if a patient needs additional guidance or has misinterpreted what we said?

**A** Communication experts suggest using a technique called "teach back" in which patients are asked to restate information in their own words. Suppose you have just finished recommending a combined cataract and glaucoma procedure. Say to your patient, "I want to make sure that I have explained why you need two different surgeries. Please tell me the two problems with your eyes that I am trying to help." Use the same approach

to clarify the goals of the surgery. "I want to make sure that I explained what vision you can expect with this type of lens. Please tell me when you might need to wear glasses." Invite input from patients who do not seem to be actively engaged in the conversation. When doing so, avoid questions with yes and no answers ("Do you have any questions about your corneal transplant?"). Instead, you and your staff should encourage patients by asking open-ended questions: "We've presented a lot of information and may not have explained everything clearly. What questions do you have for me?"

**Q** How much information should we provide to minimize claims of lack of informed consent?

**A** Plain language experts feel patients are sometimes given too much information and recommend thinking of "need to know" instead of "good to know." While this advice makes sense for clear communication, it may be problematic in the legal context of informed consent discussions. The informed consent process and forms serve a dual purpose: to inform the patient and to defend the physician against allegations of lack of informed consent. Physicians who shorten their forms and discussions too much may later be sued for failure to address certain issues. OMIC is actively exploring these issues with the help of plain language and legal consultants. We want to proceed carefully so both patients and physicians are well-served. For now, try incorporating some of these clear language principles into your conversations with patients.

1. "Plain Language: A Promising Strategy for Clearly Communicating Health Information and Improving Health Literacy." <http://www.health.gov/communication/literacy/plainlanguage/PlainLanguage.htm>.



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## Calendar of Events

OMIC continues its popular risk management program in 2015. Upon completion of an OMIC online or new PDF course, CD/DVD, 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 (indicated by an asterisk) may earn an *additional discount* by participating in an approved OMIC risk management activity. Courses are also listed on the OMIC website, [www.omic.com](http://www.omic.com).

Contact Linda Nakamura at 800.562.6642, ext. 652, or [lnakamura@omic.com](mailto:lnakamura@omic.com) for questions about OMIC's risk management seminars, CD/DVD recordings, or computer-based courses.

*My Doctor Never Told Me THAT Could Happen!* Webinar available to OMIC insureds at no charge. Contact OMIC's risk management department for more details.

### January

**17** *A Storm is Brewing: Lessons from Malpractice Settlements.* Cataract Surgery: Telling It Like It Is! Ritz-Carlton, Sarasota, FL; 1:15–2:15 pm. Sign in onsite in presentation room. Register at <http://www.cstellingitlikeitis.com/reg.html>.

**18** *An Ophthalmologist, a Priest and a Felon Walk into a Bar....* Hawaiian Eye 2015. Grand Wailea, Maui; 9:30–10:15 am. Register at <http://www.healio.com/meetings/hawaiianeyemeeting/home>.

**22** *OMIC Closed Claims.* Washington DC Metropolitan Ophthalmological Society.\* Location TBA; 6 pm. Contact [info@wdcmos.org](mailto:info@wdcmos.org).

### February

**20** *OMIC Closed Claims.* Utah Ophthalmology Society.\* Sheraton Hotel Conference Center, Salt Lake City; 12:10–12:40 pm. Sign in onsite in presentation room. Register at 801.747.3500, ext. 236, or [uos@utahmed.org](mailto:uos@utahmed.org).

**21** *OMIC Closed Claims.* Ohio Ophthalmological Society.\* Columbus Hilton at Easton; time TBA. Sign in onsite in presentation room. Register at 614.527.6799 or go to <http://www.ohioeye.org>.

### March

**6** *OMIC Closed Claims.* Illinois Society of Eye Physicians and Surgeons.\* Stephens Convention Center, Rosemont; time TBA. Contact ISEPS at 847.680.1666.

### 19 Lessons Learned From

*Malpractice Claims.* Washington Academy of Eye Physicians and Surgeons.\* Conference Center, 8th and Pike St., Seattle; 7:25–8:25 pm. Contact WAEPS at 206.956.3650.

**26** *The Risks and Benefits of Malpractice Litigation.* American Association for Pediatric Ophthalmology and Strabismus.\* Hyatt Regency, New Orleans, LA; 2:45–4 pm. Contact AAPOS at 415.561.8505.

### April

**17-21** *OMIC Closed Claims.* American Society of Cataract and Refractive Surgery. San Diego Convention Center; time TBA. Contact ASCRS at 703.591.2220 or <http://annualmeeting.ascrs.org/>.

**24-25** *OMIC Closed Claims.* Kentucky Academy of Eye Physicians and Surgeons.\* Griffin Gate Marriott, Lexington; time TBA. Contact KAEPS at 317.577.3062.