THE DIGEST
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Endophthalmitis: An updated study of claims 1987-2022

LINDA HARRISON, PhD, VP, OMIC Risk Management

Endophthalmitis occurs most often after cataract surgery and intravitreal injections, the two most frequently performed ophthalmic procedures. The effects of endophthalmitis can be devastating to vision even when diagnosed and treated in a timely fashion. Minors who suffer an infection may have to live with loss of vision, or disfigurement from enucleation or evisceration, and the associated emotional and psychological effects, for many decades. Earlier intervention increases the potential to preserve vision, or avoid enucleation or evisceration, and improves the defensibility of the care. If endophthalmitis is even a remote possibility in your differential diagnosis, see the patient as soon as possible.

OMIC has published two reports of endophthalmitis claims studies, one in 2006 and another in 2017. This issue of the Digest updates those studies with data from OMIC's endophthalmitis claims closed between January 2018 and December 2022, thereby creating a complete analysis of endophthalmitis claims experience from the time of OMIC's founding in 1987 through 2022. These historical claims studies provide perspective on underlying causes of claims and indemnity trends, and are an invaluable tool in creating risk management guidelines to improve patient safety and mitigate risk of claims.

Summary of the 2006 endophthalmitis study

This study reviewed closed claims reported from 1987 through 2005, during which endophthalmitis claims accounted for 6% of all claims and 5% of all indemnity payments. Of the 125 closed cases, 78% closed without an indemnity payment, 22% were settled, and defense verdicts were rendered in seven of eight cases taken to trial. These statistics were comparable to results for all OMIC claims in the same time period. Endophthalmitis claims were most commonly associated with cataract surgery (62%), followed by retina (18%) and cornea (11%) procedures. Indemnity payments ranged from $9,000 to $735,000, compared to $500 to $1.8 million for all payments.

Analysis of the type and frequency of risk issues revealed that nearly half of the claims involved physician issues, such as inadequate diagnostic process, poor documentation, and failure to treat and refer in a timely manner. The remainder involved systems issues, such as telephone screening, and sterilization protocols. Patient noncompliance was a contributing factor in only 5 claims.

Summary of the 2017 endophthalmitis study

The 2017 update reviewed closed endophthalmitis claims reported between 2006 and 2017. These claims accounted for 5% of all claims and 8% of all payments. Twenty-seven percent of the claims resulted in indemnity payments, versus OMIC's average rate of 20%. Again, endophthalmitis claims were most common following cataract surgery (45%) and intravitreal injections (22.5%). Claims were also filed for endophthalmitis following PPV, trauma, systemic infections, and corneal transplants. Indemnity payments ranged from $9,000 to $900,000, compared to $450 to $3.375 million for all payments.

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MESSAGE FROM THE CHAIR

ROBERT GOLD, MD, OMIC Board of Directors

It is my great honor and privilege to be your new chair of OMIC since the beginning of 2023. Now in our 36th year, we currently insure more than 6,000 ophthalmologists and provide our members with the finest claim defense and first class risk management resources and education. We are financially secure with a healthy surplus to prepare us for the future and have a stellar reputation among our colleagues in the medical professional liability community. As I start my term it is my vision that along with the incredible ophthalmologists on our board and committees and the superior OMIC staff, that we continue to build our outstanding partnership with the AAO while adapting to the ever-changing clinical, business and medical-legal climate in ophthalmology.

Shortly after I began as your chair, our CEO for the past 21 years, Tim Padovese, announced that he would be retiring effective February of 2024. While not unexpected, the news is sad for OMIC but exciting for Tim and his fantastic wife, Karen, as this is well deserved. I wanted to highlight for our members Tim's accomplishments as our CEO.

Tim was hired by OMIC in April of 2002. At that time the company had $20 million in premium, 2,400 physician policyholders, $20 million in policyholders' surplus and 22

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EYE ON OMIC

OMIC engages with cyber coverage team at TMHCC to scan websites

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Ransomware attacks have proliferated in recent years. With ophthalmology practices of all sizes increasingly using online file storage, smart phones, laptops, and tablets, they have become targets of cyber criminals. Not surprisingly, OMIC has identified a clear increase in the report of cyber claims.

Nefarious hacker gangs are endlessly searching for network vulnerabilities, scanning the web for opportunities to exploit medical practices for financial gain because health care data is extremely valuable on the dark market.

OMIC identified cybercrime as an emerging threat ten years ago and partnered with Tokio Marine HCC – Cyber & Professional Lines Group (TMHCC) to provide cyber (e-MD™) coverage as part of the standard OMIC policy. To combat cyberattacks and prevent claims, TMHCC has agreed to provide OMIC insureds with proactive vulnerability scanning that will notify you of potential exposures that could lead to a security breach. Hackers scan your domain/URL constantly to identify vulnerabilities in the same manner. Our intent is to have TMHCC conduct these scans to identify and notify you of vulnerabilities before criminals can exploit them.

Help us help you: If we have your web site domain/URL we will perform regular scans to ensure there are no intrusions that may be a threat to you. If we do not have your web site domain/URL on file, you may be contacted to provide this information. If you are contacted, please provide your web site domain/URL by following the link in the communication to update your OMIC profile.

TMHCC will scan your network monthly, searching for vulnerabilities. If anything is found, TMHCC will contact you directly with the findings and suggestions for remediation. This is a service that comes at no cost to you and is meant to be a proactive measure to thwart nefarious activity that could cause you or your practice harm.

OMIC requires vulnerability scans in order to reduce our cyber claim activity and maintain the cyber coverage benefit at current terms and rates.

What is a vulnerability scan?

A vulnerability scan is a non-intrusive scan of internet-facing systems and applications that uses nothing more than public facing domains to detect open and potentially unsecured Remote Desktop Protocol (RDP) ports, outdated software, malware from over 100 databases of known blacklists, and other cyber security vulnerabilities. These scans do not involve any penetration of your practice's firewall and is meant to provide a view of the nature of a network and, ultimately, its susceptibility to ransomware attack. Think of it like driving down the street to see which houses have left their front doors open, no trying the knob or entering required. These scans are generally done regularly, are time sensitive, and are most effective if promptly addressed.

Is any proprietary or private information shared to conduct this scan?

No. These scans are run by viewing public-facing domains, nothing more.

What is needed to run these scans?

All that is needed to run a scan is a practice entity name and its corresponding domain/URL. Once the domain is collected, it will be scanned on a regular basis. Any vulnerabilities or potential vulnerabilities will be identified and your practice will be alerted.

What happens if a potential vulnerability is identified?

A notification will be sent to the practice that includes details surrounding the vulnerability with a suggested course of action to aid in remediating the exposure. If the vulnerability is remedied, it will not be detected in the subsequent scan.

MESSAGE FROM THE CHAIR

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employees. Today OMIC has $60 million in premium, 6,000 physician policyholders, $240 million in surplus and 53 employees. Under his leadership, we have delivered over $90 million in dividends back to our policyholders. In addition, with Tim's and the board of directors' insistence, we have strengthened our partnership with the AAO.

We are indebted to Tim for his leadership of OMIC and will be celebrating with him and recognizing all of his accomplishments during this last year of his tenure. For all that have served as OMIC staff, as OMIC board and committee members, and for all of our insured ophthalmologists, fill his inbox with a message of thanks for an incredible job well done. He is a one of a kind person!

POLICY ISSUES

ROR letters and kickback investigations coverage

KIMBERLY WYNKOOP, OMIC Vice President and General Counsel

Sometimes, when patients make claims or file lawsuits against their ophthalmologists, they allege certain acts, seek monetary awards, or sue other people that aren't covered by the insured's OMIC professional liability policy. When this happens, it is OMIC's obligation to send a letter to the insured explaining who and what their policy does and does not cover.

Why did I receive a claim ROR "Reservation of Rights" Letter?

Rest assured that OMIC will assign counsel and vigorously defend a claim or lawsuit filed against you. When you receive a ROR letter, OMIC is simply reserving its right not to pay monetary awards for uncovered activities, allegations, or damages, and to withdraw its defense in the unlikely event that no allegation or defendant remains in the lawsuit that is covered by your OMIC policy.

Some of the most common reasons OMIC reserves its rights are as follows:

The plaintiff alleges intentional acts, such as intentional infliction of emotion distress, willful and wanton conduct, fraud, or false advertising. Intentional acts are often alleged so that the plaintiff can seek punitive damages. It is often against public policy to insure intentional acts. Therefore, the OMIC policy, like most professional liability policies, does not cover intentional acts. OMIC is often successful in having such allegations removed from the complaint during litigation.

The plaintiff is seeking punitive damages. Punitive damages are uninsurable in most jurisdictions, and are excluded under the OMIC policy. Again, OMIC is often successful in getting demands for punitive damages dropped.

Other allegations for which OMIC provides a conditional defense but no payment of damages are *criminal acts, sexual misconduct, acts or omissions caused by the insured's substance abuse, guaranteed results, and vicarious liability due to an apparent partnership.*

OMIC's appointed defense counsel will defend you against all allegations, not just those covered by your policy. Your counsel will work to have uncovered allegations or damages removed from the complaint, whenever appropriate.

If you receive a reservation of rights letter, don't be alarmed. Your claims representative will have discussed with you that OMIC will be reserving its rights and that a letter outlining the issues will be forthcoming. If you have questions about your coverage, please call us. Your OMIC defense attorney will do their best to protect your interests. You are always free to hire personal counsel to advise you, as well. You should also notify any other insurance carrier you have whose policy might cover the allegations or people that OMIC does not. Continuing to work closely with your OMIC defense team will give you the best chance of obtaining a swift and satisfactory resolution to the claim or lawsuit.[1]

Can OMIC help me if I'm accused of violating anti-kickback laws?

A recent multimillion dollar settlement between an ophthalmology group and the US government to resolve alleged violations of the False Claims Act and the Anti-Kickback Statute has heightened insureds' awareness of the risks associated with the remunerative arrangements ophthalmology practices have with referring optometrists who co-managed patient care.[2] This case originated from a civil lawsuit filed by a whistleblower, under the qui tam provisions of the False Claims Act, which allows private parties to bring suit on behalf of the government and to share in any recovery. It was alleged that the ophthalmology group violated the Anti-Kickback Statute, which prohibits offering, paying, soliciting, or receiving remuneration to induce referrals of items or services covered by Medicare, Medicaid, and other federally funded health care programs.

OMIC can help you if you find yourself the subject of such an investigation. OMIC's policy includes a Broad Regulatory Protection Benefit, which provides reimbursement of legal expenses and fines or penalties imposed as a result of billing errors proceedings and STARK proceedings, up to a maximum of $100,000.

A STARK proceeding means a proceeding by a government entity alleging violation of any federal, state, or local anti-kickback or self-referral laws. Billing errors proceedings include civil proceedings instituted by a qui tam plaintiff under the federal False Claims Act or by a government entity alleging presentation of erroneous billings to a government health benefit payer.

Under this benefit, the insured selects and retains their own attorney, and OMIC, through its partner Tokio Marine Houston Casualty Company (TMHCC), coordinates the reimbursement. The insured must provide timely written notice of the proceeding to OMIC's Claims Department to trigger coverage, and certain exclusions apply (e.g., criminal acts, restitution of reimbursements). Insureds are encourage to reach out to OMIC's Risk Management Department for advice on co-management to avoid these issues from the start.

[1] Policy Issues article in 2014 OMIC Digest Vol 24, No. 1. Visit omic.com/ risk-management/digests-alerts-and-bulletins

[2] US Attorney's Office, Eastern District of Texas. (2023, March 23). Ophthalmology Practice Agrees to Pay Over $2.9 Million to Settle Kickback Allegations [Press Release]. https://www.justice.gov/usao-edtx/pr/ophthalmology-practice-agrees-pay-over-29-million-settle-kickback-allegations.

Endophthalmitis: An updated study of claims 1987-2022

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Just over half of the endophthalmitis claims (55%) involved a delay in diagnosis. Delays were associated with multiple issues, including the exam and diagnostic process, follow-up interval, and documentation. Poor telephone screening accounted for one third of the diagnostic delays. Other physician treatment and decision-making issues, such as surgical technique, wound care, and delayed treatment, were significant in 25% of the claims.

The studies show that delayed diagnosis continues to be a risk issue that often leads to significant patient harm and large indemnity payments. OMIC has addressed the topic of diagnostic delay in prior issues of the Digest and in our risk management courses, yet it remains a persistent risk issue in settled claims.

Have we made any progress in reducing diagnostic delay as a risk factor? Read on to find out.

The current study

The current study reviewed all endophthalmitis closed claims between January 2018 and December 2022. The 83[1] claims in the study, involving 47 patients, represent 6.8% of all claims closed during this timeframe, an increase from the 2017 study (5%) and the 2006 study (6%).

Not surprisingly, the diagnosis of endophthalmitis occurred most frequently following cataract surgery (49%) and intravitreal injections (36%). Table 1 shows the distribution among the procedures.

Indemnity and expense payments

In 22 of 47 cases an indemnity payment was made; payments ranged between $29,999 and $1.9M (See Table 2). The average endophthalmitis payment was $357,450, compared to OMIC's average indemnity payment of $262,000. Total endophthalmitis indemnity paid was $7.8M, while expenses paid totaled $3.2M.

Patient outcomes

For all but 2 of the 47 patients, the diagnosis of endophthalmitis resulted in significant vision loss to 20/200 or worse (visual acuity of HM, LP, NLP). Six patients underwent enucleation, while 2 required evisceration. The ultimate visual acuity for 1 patient is unknown. The two patients who did not suffer vision loss had documented poor visual acuity prior to their respective procedures.

Defensibility of claims

Defense experts opined that the standard of care was met in approximately 30% of cases, and the majority of these lawsuits were dismissed, with two exceptions. In one case involving endophthalmitis following cataract surgery that resulted in evisceration, the defense attorney estimated the chance of a defense verdict at 75% to 80%, and a verdict range of $1.5M to $2M. The insured demanded that OMIC settle the case to avoid the potential of an excess verdict. The second case, described below, was taken to trial.

TABLE 1. ENDOPHTHALMITIS CASES BY PROCEDURE

Procedure	Number of Patients
Cataract surgery	23
Injection	17
Other retina	3
Strabismus surgery	2
IOL exchange	1
Patient referred for enucleation for presumed retinal melanoma (pathology showed necrotizing granulomatous scleritis)	1
All Procedures	47

The *event* in the trial case

The patient, who had pseudoexfoliative cataracts (PXF), left greater than right, underwent cataract surgery. The informed consent discussion was documented and included references to the patient's higher risk due to Flomax use, PXF, miotic pupil, and dense cataract, and that the patient was advised of the implications of preexisting comorbid eye disease and limitations that would exist even after surgery. The surgery was complicated by capsular rupture with instability, IFIS, dislocation of the intraocular lens, and retained lens fragments.

On postop day one, the cataract surgeon diagnosed inferior nuclear lens fragments in the vitreous, corneal edema, moderate inflammation, IOP of 39 and dislocated IOL, and immediately referred the patient to retina defendant #1. Exam findings by the retina specialist included inferior nuclear lens fragments in the vitreous, corneal edema and moderate inflammation, IOP of 39, and dislocated IOL; continued use of IOP lowering drops and antibiotic/steroid drops were recommended. Surgery to remove lens fragments was scheduled for 2 days later. The exam just prior to surgery revealed visual acuity of NLP, markedly increased ocular inflammation, hypopyon, and severe corneal inflammation and edema. The surgeon discussed the findings and the suspected endophthalmitis with the patient and family, recommended additional treatment for the infection during the surgery, and warned of a guarded prognosis. The consent form was amended to include the endophthalmitis treatment, and signed by the patient. The cultures grew staph aureus. Unfortunately, the patient's vision remained NLP.

The *outcome* of the trial case

The patient sued the cataract surgeon and the practice, as well as both retina specialists and their practices (5 insureds), but eventually dismissed the cataract surgeon and practice and retina specialist #2 who had little involvement. The plaintiff's primary theory was that there was evidence of infection during the exam by retina specialist #1, and the diagnosis should have been made and treatment begun, which would have produced a better outcome. Due to strong standard of care support by experts, and supportive internal reviews, the case was tried and the jury returned a unanimous defense verdict. Total defense costs were approximately $450,000.

This case provides an example of how timely and forthright communication, thorough documentation, and a prompt response to postoperative complaints support both good patient care and defensibility of claims.

Both the cataract surgeon and retina specialist #1 defendants followed these principles, demonstrating at trial that even in the face of a complicated surgery and a poor patient outcome, good care can be successfully defended.

TABLE 2. INDEMNITY PAYMENT RANGES							
	$1M-2M	$500k-999k	$400k-499k	$300k-399k	$200k-299k	$100k-199k	Under $100k
Number of cases	1	2	1	4	5	6	3

Risk management recommendations:

√ When a patient has a higher risk profile for a medication or procedure, document that you discussed that with the patient, answered questions, and noted the patient's acknowledgement and desire to proceed..

√ If the patient does not wish to proceed, you must advise the patient of the associated consequences, and document that discussion.

√ After your consent discussion, obtain the patient's signature on the procedure-specific consent form, retain the original in the medical record, and give a copy to the patient.

√ If there are changes in surgical goals or to the planned procedure, document those in the medical record, and amend the consent.

Contributing factors: What has changed?

The two prior studies found that physician issues were a significant factor in approximately half of the claims and, in the 2017 study, 55% of claims involved a delay in diagnosis. The most recent data reveals that diagnostic error was less prevalent, at 30%. However, in nearly half the cases (49%) a physician issue was a significant contributing factor that led to poor outcomes, a finding consistent with the prior studies. In addition to diagnostic error, these physician issues included poor sterile technique, poor management of operative complications, and a delay in treatment.

Poor sterile technique

The 7 lawsuits alleging that poor sterile technique led to endophthalmitis and loss of vision resulted in settlement. Experts opined that the breaches in aseptic protocols fell below the standard of care in six of the cases. In one suit, experts disagreed about whether the standard of care required the use of masks and gloves.

Managing postoperative complaints

The majority of patients follow postoperative instructions, and will call as directed to report concerning symptoms. We have few examples of patients whose calls were unwarranted. Some insureds responded to patients' calls with an "offer" to see the patient. This puts the decision of whether to be medically evaluated in the hands of the patient. The patient or caregiver is not equipped to make that decision, and plaintiff attorneys will often make that argument. The physician must make this decision. Evaluation via telemedicine may be helpful in determining if a watch-and-wait approach is prudent, but if that approach is chosen, physicians must periodically monitor the patient for changes, especially if endophthalmitis is a concern.

A frequent dilemma is encountered with patients who have postoperative complaints but live some distance from the surgeon, cannot find transportation, or are simply reluctant to come in to the office or hospital on a weekend or at night. In such cases, you, the physician, must advise the patient that the problem cannot be adequately evaluated over the phone, and that the patient needs to be seen in-person.

You should clearly state the potential consequences (based on your best medical judgment) of waiting to be seen. Consider if there are any alternatives, such as an ophthalmologist or hospital that is geographically closer to the patient. The patient's response might indicate the need to have them repeat your advice in their own words to help confirm their understanding. It is imperative that you document what you advised, the patient's response, and the plan, and add this to the medical record as soon as possible. Do not keep such communication notes on your own computer or in "shadow charts."

In several cases, patients who called with postoperative complaints were given appointments the following day, but scheduled in the afternoon, sometimes as late as 5pm. This can delay treatment, particularly if the patient needs referral to another specialist outside of your office or to the hospital.

Our reviews of the most severe cases have shown that earlier intervention may have mitigated catastrophic consequences. If endophthalmitis is even a remote possibility in your differential diagnosis, see the patient as soon as possible.

Consider arranging your schedule so that you can see such patients at the beginning of your day, or simply come into the office early for that patient. If the patient voices resistance, advise them of the importance of being seen as soon as possible. Instructions about when to come into the office and resistance from the patient should also be documented in the medical record.

Systems issues

Systems issues were significant factors in 2 cases, and both involved management of patients' postoperative complaints. In one case, staff did not notify the surgeon of a patient's call regarding loss of vision until approximately 5 hours after the call. In the other case, there was a dispute regarding whether the patient ever reported vision loss, as there was no documentation of calls. While staff denied receiving any calls, and credibly testified to their custom and practice of always reporting symptoms to a physician, there was no documentation to support their position. Both cases were settled.

Contributory negligence

Patients' own negligence was the chief contributing factor in 2 cases. In one case the patient failed to return for postoperative care, and in the other case the patient delayed reporting symptoms suggestive of endophthalmitis for over 24 hours despite postoperative instructions that clearly advised the patient to report such symptoms promptly. Neither patient pursued a claim of malpractice.

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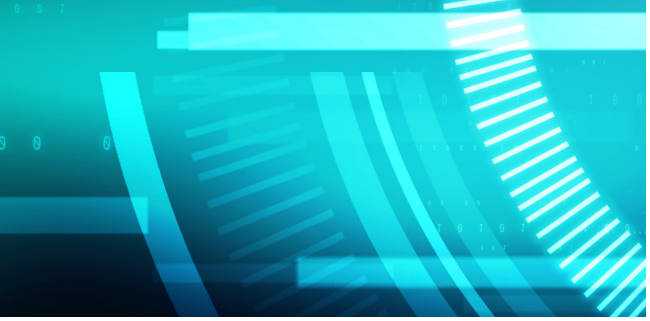

CLOSED CLAIM STUDY

When diagnosing endophthalmitis, the sooner the better

RYAN M. BUCSI, OMIC Claims Vice President

Allegation

Delay in diagnosis of endophthalmitis OS following bilateral strabismus surgery resulting in HM OS and phthisis bulbi in a 5-year-old child.

Disposition

Settlement of $850K.

In 2017, a minor patient and the parents presented to the insured due to the right eye turning inward. Strabismus surgery was discussed during this examination, but the parents opted to continue using bifocals for another year.

Upon returning to the insured in 2018, both eyes were now turning inward. Therefore, the patient's parents consented to bilateral strabismus surgery. The insured performed bilateral strabismus surgery without complication. The parents were instructed to call the insured should the eyes become pink or swollen, or if the eyelids became markedly red, swollen, or tender. A follow-up appointment was scheduled for postoperative day 4. On postoperative day 3, the patient's mother called the insured to report that the left eye was a little red temporally and that the patient could not open that eye. The mother texted a photo of the eye to the insured. The insured ordered Keflex and instructed the mother to keep the appointment for the next day.

When the patient presented for the first scheduled postoperative examination, the insured noted 2+ injection of the conjunctiva, and 3+ cell and flare in the anterior chamber of the eye. The fundus was also noted to be hazy on the left. The insured asked a retina colleague to examine the patient to rule out endophthalmitis. [The retina colleague suspected endophthalmitis and] the patient was instructed to go to the emergency room. At the hospital the patient was taken to the operating room for an examination of the eye under general anesthesia. During this examination endophthalmitis of the left eye was diagnosed and treated with a vitreous tap and injection.

The plaintiff alleged that, as a result of the delay in diagnosis of endophthalmitis, the patient developed multiple retinal detachments that had to be repaired surgically, resulting in hand motion vision in the left eye.

Analysis

Plaintiff retained two expert witnesses who were critical of the care provided by our insured. Both experts believed that our insured violated the standard of care by failing to recognize the "hallmark features" of endophthalmitis such as chemosis and erythema. These were the same features that were described in the postoperative instructions that were given to the parents. The experts also believed that the insured violated the standard of care by prescribing oral antibiotics for pre-septal cellulitis without ruling out endophthalmitis. Both experts felt that the failure to examine the patient at the earliest opportunity was a violation of the standard of care. Plaintiff's experts also stated that the insured's failure to examine the patient when the mother called allowed the endophthalmitis to progress resulting in a significant increase in the risk of developing PVR and permanent severe vision loss. Plaintiff's experts also opined that the insured should have seen the patient first thing the next morning versus keeping the set appointment, which was scheduled for the end of the day.

OMIC had the case reviewed by 3 defense expert witnesses and one of the witnesses was fully supportive of the care rendered by the insured. Our expert did not believe the photo raised any red flags for endophthalmitis since there was no massive swelling present. Our expert opined that the care plan of prescribing antibiotics for potential cellulitis was entirely reasonable. Our expert also believed that the plaintiffs would make an issue of the patient not being seen first thing the next morning, but since the insured was not concerned with endophthalmitis, it was appropriate to keep the afternoon appointment.

Takeaway

It would have been risky to try this case in front of a jury with a young child who experienced a complete loss of vision in one eye with phthisis bulbi. There was the potential for a large plaintiff verdict, so the case was settled prior to trial. If endophthalmitis is remotely suspected, it is best to err on the side of caution and either ask the patient to come into the office immediately, or instruct them to go to the closest emergency room.

Furthermore, if endophthalmitis is suspected in the evening, it would be advisable to make sure the patient is seen as a priority the next morning. The quicker the diagnosis of endophthalmitis is made, the better the outcome for the patient and the defensibility of the claim.

SOCIETY PARTNERS

Supporting your ophthalmic society lowers your OMIC premium

Earlier this year, OMIC automated our risk management discount process to improve efficiency and free staff to perform more customized services for our insureds.

We believe these changes have been very beneficial not only for staff, but also our policyholders, who now have easier and more convenient options to earn discounted premiums and access our resources.

Another change implemented was the automation of our society partner discounts and making them easier to obtain. These discounts are now self-directed so it is important that insured physicians maintain current information in their online profile to ensure that discounts are appropriately applied to the OMIC policy renewal.

Visit OMIC's website and sign into your MyOMIC profile to update your current active society memberships. OMIC has partnerships with most ophthalmic societies in the United States. Simply check the box of any societies you maintain a membership in at least 60 days prior to your renewal date for the discount to be automatically applied. A maximum of 5% in society partner discounts is available per policy year.

OMIC may periodically audit society membership status at its discretion to ensure accuracy, so please keep your status as an active member of your society up-to-date. Any changes to society membership should be reflected in your profile as they occur.

The following list of societies maintain a partnership with OMIC and qualify you for the premium discount. Our first partnership was established nearly 30 years ago. Since then, our insureds have earned $35 million in OMIC partner society discounts. We are proud to support organizations that defend the profession and help to lower risk by disseminating critical patient safety information. If you do not see your ophthalmic society listed, reach out to them and encourage their leadership to establish a partnership today.

State and regional partner societies

Alabama Academy of Ophthalmology
Arizona Ophthalmological Society
Arkansas Ophthalmological Society
California Academy of Eye Physicians & Surgeons
Colorado Society of Eye Physicians & Surgeons
Connecticut Society of Eye Physicians
Delaware Academy of Ophthalmology
Florida Society of Ophthalmology
Georgia Society of Ophthalmology
Hawaii Ophthalmological Society
Idaho Society of Ophthalmology
Illinois Society of Eye Physicians & Surgeons
Indiana Academy of Ophthalmology
Iowa Academy of Ophthalmology
Kansas Society of Eye Physicians & Surgeons
Kentucky Academy of Eye Physicians & Surgeons
Louisiana Academy of Eye Physicians & Surgeons
Maine Society of Eye Physicians & Surgeons
Maryland Society of Eye Physicians & Surgeons
Massachusetts Society of Eye Physicians & Surgeons
Michigan Society of Eye Physicians & Surgeons
Minnesota Academy of Ophthalmology
Mississippi Academy of Eye Physicians & Surgeons
Missouri Society of Eye Physicians & Surgeons
Nevada Academy of Ophthalmology
New England Ophthalmological Society
New Hampshire Society of Eye Physicians & Surgeons
New Jersey Academy of Ophthalmology
North Carolina Society of Eye Physicians & Surgeons
North Dakota Society of Eye Physicians & Surgeons
Ohio Ophthalmological Society
Oklahoma Academy of Ophthalmology
Oregon Academy of Ophthalmology
Pennsylvania Academy of Ophthalmology
Rhode Island Society of Eye Physicians & Surgeons
South Carolina Society of Ophthalmology
Tennessee Academy of Ophthalmology
Texas Ophthalmological Association
Utah Ophthalmology Society
Vermont Ophthalmological Society
Virginia Society of Eye Physicians & Surgeons
Washington Academy of Eye Physicians & Surgeons
Washington DC Metro Ophthalmological Society
West Virginia Academy of Eye Physicians & Surgeons
Wisconsin Academy of Ophthalmology
Wyoming Ophthalmological Society

Subspecialty partner societies

American Association for Pediatric Ophthalmology and Strabismus
American Glaucoma Society
American Society of Ophthalmic Plastic and Reconstructive Surgery
American Society of Retina Specialists
North American Neuro-Ophthalmology Society
The Retina Society
Vit-Buckle Society

Special interest partner societies

American Eye Study Club
Eye and Contact Lens Association
Women In Ophthalmology

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Diagnostic error

Diagnostic error can be defined as a diagnosis that is delayed, missed, or wrong, based on subsequent test results or clinical evidence, and the resulting patient harm is directly related to the error.

In OMIC's entire claims history, 27% of settlements have been related to diagnostic error cases, with an average payment of $300,000 per claim, compared to an average payment of $262,000 for all other cases (i.e., not involving diagnostic error). In the present study, 11 of 22 settled cases involved diagnostic error, and it was a significant contributing factor in the largest indemnity payments; the average payment per claim with this issue was $342,000.

Several aspects of the diagnostic process, such as managing postoperative complaints and documenting communication, were prominent barriers to making a timely diagnosis, and resulted in settlements, as described below:

The differential diagnosis

In 27% of settled cases, we learned that insureds were concerned about endophthalmitis, but the concern was not included in the differential. Furthermore, some physicians did not proactively monitor patients to rule out the possibility. If you are concerned about endophthalmitis, document that in your differential and rule out the diagnoses in the order of severity and risk to vision. Carefully monitor any test results so that any necessary treatment is begun in a timely fashion.

Conclusion

Based on our claims analysis in this and prior studies, it bears repeating that earlier intervention may mitigate catastrophic consequences. If endophthalmitis is even a remote possibility in your differential diagnosis, see the patient as soon as possible. If patients decline to be seen, document your advice about potential consequences and urge compliance. Monitor patients for progression of symptoms and document the interactions.

Use the differential diagnosis to show your thought process regarding the patient's condition. You must actively pursue each potential diagnosis, from the most to least vision-threatening, until you have a final diagnosis. Continue to monitor patients during the process. Clear and contemporaneous documentation demonstrates your thought process, benefitting both patient care and defensibility of the claim in the event a patient pursues legal action against you.

Document all communication with patients and place the notes in the medical record. Train your staff and periodically reinforce the importance of promptly notifying physicians of all postoperative complaints and documenting all communication with patients. Let staff know that they play a crucial role in patient safety, and you rely on them as part of the team.

[1] Some of the 47 patients brought claims against multiple physicians, and/or the physician's practice, totaling a combined 83 claims. For much of the data analyzed, we have grouped all of the claims by one patient together as one "case." So, while there are 83 claims in the study, there are 47 cases.

UPCOMING EVENTS

Ophthalmology Virtual Journal Club

The Ophthalmology Virtual Journal Club is a new Academy member benefit featuring experts who will break down a published paper's findings and implications. The quarterly live-streamed webinar will feature slides, curated feed of questions, and allow participants to post questions on the chat as well as a dedicated Q&A portion toward the end of the live stream.

The next webinar is set for October 12, 8:30-9:30 pm ET and will be featuring OMIC board member Dr. Guarav Shah. Two articles will be discussed including Timing of Delayed Retinal Pathology in Patients Presenting with Acute Posterior Vitreous Detachment in the IRIS® Registry (Intelligent Research in Sight) and Analysis of Posterior Vitreous Detachment and Development of Complications Using a Large Database of Retina Specialists.

A link to the October 12th webinar will be distributed prior to the event. You will need your Academy login to watch. Not a member? (Learn about the value of Academy membership: https://www.aao.org/membership)

AAO 2023 Annual Meeting

Please join us at the AAO Annual Meeting in San Francisco. We will be offering OMIC courses to physicians, technicians, nurses, and administrators. Service representatives for OMIC and our cyber, regulatory, and life and health insurance partners will be at the OMIC booth in the exhibit hall adjacent to the Academy Resource Center. Information will be posted on OMIC's web site and distributed to insureds prior to the meeting.

RESOURCES

Home study

Earn a 5% risk management discount by completing one of our online courses, made available exclusively to OMIC insureds: omic.com/risk-management/education/online-and-recorded-courses.

Live seminars

Upcoming risk management presentations are posted here: omic.com/calendar.

Library

For a complete online library of forms, documents, and recommendations, visit omic.com/risk-management.

Alerts and bulletins

OMIC publishes risk management recommendations on hundreds of topics that help insureds in their daily practice, from responding to medication recalls to managing challenging patient situations: omic.com/risk-management/digests-alerts-and-bulletins.

Risk management hotline

Our confidential risk management hotline is available exclusively for OMIC insured physicians and staff members who need risk management assistance.

Message the hotline at riskmanagement@omic.com for non-urgent issues and we will respond promptly.

For urgent issues or to speak with the risk manager on duty call (800) 562-6642 (Press 4).

Partnerships

Earn a 5% premium discount by joining and maintaining membership in one of our partner societies listed on our website at: omic.com/partners. Update your society memberships in your OMIC profile at: omic.com/UserAccounts/login

AAO store

The AAO store has excellent patient education videos on a variety of topics: store.aao.org.