THE DIGEST
OPHTHALMIC MUTUAL INSURANCE COMPANY VOLUME 34 NUMBER 1 2024

Never events in focus: Incorrect gas claims

LINDA HARRISON, PhD, VP, OMIC Risk Management

This edition of the Digest reports the analysis of closed claims between 1/1/2009 and 12/31/2022 involving the administration of the incorrect type and concentration of gas, which are considered "never events."

Never events

Never Events are deemed the most egregious type of Adverse Event because they are preventable and should never happen. Never Events include incidents involving the wrong patient, wrong body part, wrong procedure, wrong medication, and retained foreign bodies. The term Never Events was coined in 2001 by Ken Kizer, MD, the former CEO of the National Quality Forum (NQF), to describe medical errors that are preventable and should not occur. The Agency for Healthcare Research and Quality (AHRQ), through its Patient Safety Network, defines Never Events as "unambiguous (clearly identifiable and measurable), serious (resulting in death or significant disability), and usually preventable."

The high cost of wrong gas claims

Payment was made to a claimant in 23% of all OMIC claims closed from 2009 through 2022. These indemnity payments totaled $152 million, and the average payment was $238,000. Of these closed claims, retina claims, at 23%, comprised the highest volume after cataract claims, and accounted for 21% of all indemnity payments, at $32 million.

In this time period, only twelve (or 2%) of the 641 total retina claims involved the wrong type or concentration of gas, but all twelve closed with an indemnity payment and represent over 17% of the total indemnity paid for retina claims. Patient outcomes were severe. To wit, the best visual outcome was counting fingers at 3 feet (1 patient), followed by hand motion (HM) (2 patients), no light perception (NLP) (7 patients), phthisis bulbi (1 patient), and enucleation (1 patient). A poignant aspect of these catastrophic injuries is that they most likely could have been avoided had applicable safety protocols been followed.

What factors made these gas errors possible?

Analysis of these wrong gas claims provides insight into the role of training, communication, and documentation, both in reducing the probability of error and understanding how the error occurred. Failures in various aspects of communication, including documentation, timeouts, and clarification of physician orders, contributed to the errors. The most significant failure, and the step that, if taken, could have prevented some of the errors, involved confirming the correct gas and concentration before injecting it.

When the wrong type or concentration of gas was prepared, we learned that the error stemmed from a lack of training in preparing gas, unfamiliarity with the technology involved, or failure to orally clarify any questions before proceeding.

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MESSAGE FROM THE CHAIR

ROBERT GOLD, MD, OMIC Board of Directors

It is my honor and privilege to be the Chair of the Board for our malpractice company, OMIC. Our company continues to be financially sound and stable with continuous growth over its 37 year history. We now insure over 6,400 ophthalmologists in all 50 states. We have an "A" rating from AM Best and continue to be a leader in the medical professional liability space. We give back to our insureds each year by dividend credits that decrease your policy premium on your renewal date as you continue to support our OMIC mission. We continue to have superior claims representation, with spectacular results, as well as risk management resources that are second-to-none in our field.

We also have had a very special partnership with the American Academy of Ophthalmology since day 1 of our existence. This partnership continues to grow under the leadership of the AAO's CEO, Stephen McLeod, MD. At this year's AAO annual meeting in Chicago, OMIC has the incredible priviledge of receiving the 2024 Distinguished Service Award. This award is one of the Academy's highest honors that recognizes OMIC's ongoing service to ophthalmology and

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EYE ON OMIC

OMIC's latest policyholder dividend places us ahead of peers

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

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We are pleased to report that OMIC continues to perform as one of the most fiscally sound insurance companies in America. Our results through September 30 show policyholder growth has exceeded our year-end projections, surpassing 6,425 insured ophthalmologists.

As we forecast our full-year performance, it is clear that OMIC will again produce solid, profitable results despite an industry-wide uptick in both frequency and severity of claims and rising litigation costs. We remain laser-focused on managing these inflationary trends and continuing to vigorously defend claims, while at the same time streamlining processes and reducing expenses whenever possible.

OMIC has an impressive decades-long history of consistent premium rate stability. Our average rate of $10,400 for a surgical ophthalmologist is just 11% higher than the average was in 1992 ($9,400). This modest increase, over more than three decades, is remarkable considering the increase in the CPI of 225% during the same period. OMIC's average rates have historically been significantly lower, on average, than multispecialty peers within our industry for ophthalmology.

In addition to rate stability, we continue to return any premium to our members above that which is necessary to prudently run the company. Since 1992, OMIC has declared and returned more than $105 Million to policyholders through dividend credits. This is an average of approximately 8% or $975 per insured per year with the cumulative return surpassing $26,250 per insured ophthalmologist (or equal to two and a half years of coverage).

In keeping with that commitment, we are pleased to announce a 5% dividend credit, which will be applied to your 2025 renewal policy premium. Of 50 companies actively writing medical professional liability insurance, only 25% of them, including OMIC, issued dividends each year during the past decade. More than half issued no dividends at all during that period. Among the quarter of insurers issuing consistent returns, OMIC's average dividend of 15% significantly exceeded the industry average.

OMIC is unique within our industry with regard to our continuing issuance of policyholder dividends during the current inflationary environment. With our latest declared dividend, OMIC will have issued dividends in 30 of the past 38 years. Your support of our program has contributed immensely to the continued growth of our company and these consistent returns.

OMIC's "A" rating by AM Best is reaffirmed

Once again, OMIC's strong balance sheet was referenced by AM Best when they reaffirmed our "A" Excellent financial strength rating for 2024. In reaffirming our rating, AM Best noted that: *"OMIC maintains the strongest level of risk-adjusted capitalization possible as measured by our analysis and has a long-term history of organic surplus growth despite substantial policyholder dividends, which is a function of its commitment to its members."*

MESSAGE FROM THE CHAIR

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the Academy. Dr. McLeod stated in his invitation, "It recognizes OMIC for its enduring relationship with the Academy and the invaluable impact that OMIC has had on the Academy members, their patients, and the field of ophthalmology." Bill Fleming, OMIC's President and CEO, and I will represent OMIC at the Opening Session on Saturday morning, October 19, from 9 am-1030 am in the Grand Ballroom at McCormick Place Convention Center. Please join us to help celebrate this award given to our company!

Finally, I want to thank my fellow Board and committee members, each of whom is a leader in their particular specialty of our profession. These colleagues represent all 6,400 of us, whether it is analyzing a claim, educating us in risk management topics, or working with our stellar OMIC staff in claims, risk management, underwriting, sales, and finance to continue to keep OMIC the leader in the ophthalmic malpractice insurance industry.

POLICY ISSUES

Office surgical suites

NEIL SIMONS, VP, OMIC Underwriting

While not a new concept, office surgical suites have certainly become more prevalent in recent years. They can provide a safe alternative to using full ambulatory surgery centers for many procedures. It is often easier for ophthalmologists to treat their own patients in-office rather than contending with the scheduling conflicts that may occur at many ambulatory surgery centers. Generally, procedures are performed in an office surgical suite for the convenience of both the ophthalmologist and the patient. Additionally, office surgical suites provide an increased and more cost effective revenue stream for the physician.

OMIC supports the use of office surgery suites for many procedures. Naturally, patient safety is of paramount importance. If an ophthalmologist is going to perform procedures in an office surgical suite proper precautions should be taken to ensure patient safety and good outcomes.

The following **OMIC Underwriting Guidelines** should be implemented by insureds prior to performing intraocular procedures in an office surgical suite:

1. The facility must follow all federal, state, and local laws and regulations applicable to office-based surgery (if any).

2. If the ophthalmologist wishes to perform intraocular procedures in their office surgical suite it must be accredited (or pending accreditation) by any of the following:

AAAASF, AAAHC, The Joint Commission, or ACHC (formerly HFAC).

3. Patients must be at least 18 years of age to undergo incisional intraocular surgery in an office setting.

4. Patient selection criteria is critical and operations must be limited to ASA Physical Status Class P1 or P2.

5. Anesthesia must be limited to topical, local injection, and minimal sedation (anxiolysis). Exceptions to permit moderate ("conscious") sedation may be granted subject to Underwriting review.

6. Any requested oculoplastic procedures desired to be done in an office surgical suite must be reviewed through OMIC's physician review process.

7. OMIC should also be notified to ensure proper coverage is in place.

In addition to these requirements, physicians should ensure that the level of care provided during the procedure is the same as would be provided in a traditional outpatient surgery center or hospital setting. The physician and facility should also be prepared to handle any intraoperative emergencies that may arise, and it is recommended that the physician maintain admitting privileges at the nearest hospital. A robust system for follow-up care should also be in place. As is always recommended, proper informed consent procedures should be followed.

Finally, the administration of anesthesia (other than local or topical) is best done by an anesthesiologist or Certified Registered Nurse Anesthetist.

If you have any questions or need additional help, please contact OMIC's Underwriting Department at (800) 562-6642 ext. 676.

Office based surgery for adults: a deeper dive

Some ophthalmic surgical procedures can be safely performed in an office surgical suite. Others with higher risk profiles raise a number of concerns. If a patient experiences a serious complication or poor outcome and decides to sue the ophthalmologist, all aspects of the care will be questioned, including the decision to perform the procedure in the office.

Regardless of the setting of the surgery (office, ASC, or hospital), the same standard of care applies, and the safety of the patient should be the guiding principle in the decision-making process.

OMIC has published suggested risk management recommendations (RMRs) on a variety of topics to help you ensure patient safety and reduce your professional liability risk should adverse events occur.

Our RMR guide for office based surgery for adults covers the following recommended practices and protocols and includes detailed explanations and examples for each item:

1. All procedures and protocols should be in writing and reviewed and updated regularly with staff.

2. Procedure and patient selection criteria should meet all recognized professional standards.

3. A detailed plan for monitoring patients should be implemented and well documented.

4. Worst case scenarios should be anticipated with response actions rehearsed and relevant emergency equipment available.

In addition, we include links to many related resources so that you may research and implement the appropriate plan for your practice.

To download OMIC's comprehensive Risk Management Recommendations Guide for Office Based Surgery for Adults, visit **omic.com/office-based-surgery-for-adults-recommendations**.

Never events in focus: Incorrect gas claims

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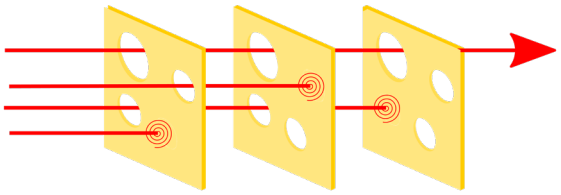
Sometimes staff believed they were preparing the gas as ordered, but they unknowingly misinterpreted the physician's order. Staff who encountered a new technology for obtaining the gas did not ask questions about how to use it, and instead made assumptions, which led to incorrect concentrations. In one case, the wrong canister of gas was inadvertently chosen from a drawer that contained different types of gas, all housed in canisters of the same size and shape with similar markings. The tech explained he was rushing and had grabbed the canister quickly. Unfortunately, the physician did not notice that the type of gas was incorrect.

Timeouts did not always prevent a wrong gas error. Medical records in some of the claims documented a timeout, and operative reports noted the correct concentration and type of gas. The claims illustrate that confirming the gas concentration with staff before injecting did not always ensure it was correct. When staff erroneously believed that they had diluted the gas as ordered, they confirmed they carried out the physician's order. In one case, the insured requested 14% C3F8 gas, and watched the surgical assistant enter 14 into a vitrectomy machine that the surgeon was unfamiliar with. The assistant confirmed the 14% C3F8 gas and the surgeon injected it, even though the surgeon wondered why the syringe only contained 20cc versus the 60cc that he expected. Only after injecting did the surgeon ask about the volume in the syringe. It was later discovered that the assistant was not clear on how to use the machine, which only provided 100% C3F8 gas. This example also illustrates the importance of clarifying before acting.

When surgeons did not mix the gas themselves, retained experts disagreed whether the standard of care required the surgeon to observe the staff who mixed the gas and to orally confirm the gas concentration that was prepared and provided. Some states have not upheld the "Captain of the Ship" doctrine, which states that physicians may be held responsible for the acts of others who are under their direct supervision and control. Even so, a physician is responsible for the medication that he or she administers. OMIC provides recommendations for using timeouts: https://www.omic.com/wp-content/uploads/2016/09/Time-Outs-For-Procedures-2.pdf

We often hear that Never Events are avoidable. If that's true, why do they continue to occur? While it's impossible to completely eliminate errors in healthcare due to human factors, it is possible to reduce their frequency, and hence also reduce patient harm. The medical error literature cites communication failures and systems failures as the primary culprits. As Professor James Reason's Swiss Cheese Model for risk analysis illustrates, every safety protocol has vulnerabilities, but a series of safety protocols may catch human error before it results in harm. Therefore, implementing safety protocols at critical junctures in patient care offers multiple opportunities to fill process holes to avoid errors. However, multiple steps do not guarantee that a risk can be avoided. As the illustration demonstrates, while the first three protocols each prevented an error, one error made it through the entire series of protocols.



Therefore, implementing safety protocols at critical junctures in patient care offers multiple opportunities to fill process holes to avoid errors. However, the model cautions that multiple steps do not guarantee that a risk can be avoided, as illustrated in the aligned holes at the top left.

Ongoing training when new technology is introduced, reviewing safety protocols, and practicing effective communication that emphasizes clarity, accuracy, transparency, and urgency, are strategies to reduce errors.

When a wrong event occurs

Physicians have an ethical responsibility to disclose adverse events, and patients have a right to know what has occurred. Disclosure is important for patient safety, patient trust, patients' ability to make decisions about treatment, and continuity of care among providers. Disclosure is also an opportunity to show empathy and repair any damage to the physician-patient relationship.

In some states, disclosure is legally required, so you should know the applicable laws where you practice. When you have confirmed that a medical error occurred, the error should be documented in the medical record and disclosed to the patient. Studies have shown that transparency and empathy can strengthen the physician-patient relationship and potentially reduce the chance of litigation. There are legal and ethical considerations to be aware of when communicating to patients about the details of adverse events. Obstacles that may impede disclosure include fear of retaliation, lack of training, culture of blame, and fear of litigation.

Disclosure doesn't necessarily stop individuals from pursuing litigation, but withholding information could be a catalyst for litigation and potentially inflate the value of a claim. Insureds often ask about how an apology might affect their liability should the patient file a lawsuit. Only a few states' laws provide full apology protection, meaning you can tell a patient you made a mistake and that statement will not be admissible as evidence of negligence in a lawsuit. Most states that have apology laws provide only partial protection. While expressions of sympathy will not be admissible as evidence of negligence, admissions of errors will be. Even in these states, we recommend you consult with your insurer or attorney first to ensure your disclosure will be protected.

For more information see: **https://jaapl.org/content/early/2021/05/19/JAAPL.200107-20**

Check your state laws concerning apologies: **https://www.ncsl.org/financial-services/medical-professional-apologies-statutes**

In one of the wrong gas claims, the patient testified in deposition that the physician had painted an overly optimistic picture of the procedure, and downplayed potential risks. Whether or not that recollection was accurate, it reminds us that it is important to be realistic in the informed consent discussion. The patient had set high expectations for an excellent outcome without complications. Furthermore, before the investigation of the error was complete, the physician shared with the patient the hypothesis that the wrong gas was injected. While that was a reasonable assumption given the patient's symptoms, it was never proven, and other known risks of retina surgery could have led to the same postoperative course. The hypothesis gave the patient a reason to file suit. Due to many factors, the claim was settled for $1 million. It is imperative to disclose only known facts and not hypothesize or place blame.

OMIC recommendations: **https://www.omic.com/wp-content/uploads/2024/08/Disclosure-of-Adverse-Events.pdf**.

Being involved in a Never Event can be stressful, even if you did not have a primary role in the event. Subsequent treaters are often asked to give opinions about what went wrong, what you would have done, and to make judgments about the facility and other providers. Remember that in addition to the resources noted above that can be found on our website, OMIC Risk Management staff are available to answer your questions at riskmanagement@omic.com or 800-562-6642, option 4.

The Swiss cheese model illustration on pg 4 is by Ben Aveling, used under CC BY-SA 4.0, available at https://commons.wikimedia.org/wiki/File:Swiss_cheese_model_textless.svg.

THE DISCLOSURE PROCESS

1.	**Focus** on the patient's condition and treatment needs.
2.	**Preserve any evidence** related to the event (example: equipment, devices, medication, packaging).
3.	**Contact OMIC Risk Management** for advice.
4.	**Debrief** with the staff involved to gather facts.
5.	**Develop** a disclosure plan.
6.	**Disclose** the facts of the event to the patient and/or family. **Who**-attending/treating physician; other members of the healthcare team can be included **What**-known facts only; do not hypothesize, blame others, or admit negligence; use plain language **When**-as soon as possible after the event; patient should not be under the influence of anesthesia **Where**-in a confidential setting **How**-with empathy, understanding, and transparency Example: "I understand this was not the outcome we all hoped for. I can only imagine how difficult this must be for you. I'm reviewing what happened and will keep you informed as I learn more." NOT "I'm sorry, I made a mistake."
7.	**Advise** of possible short-term or long-term effects of any injury resulting from the event and next step steps in the treatment.
8.	**Share** your contact information and follow-up time frames to set expectations and alleviate concerns.
9.	**Document** disclosure communication with the patient and/or family in the medical record.
10.	**Perform** a root cause analysis. Example can be found at VA.gov. **https://www.patientsafety.va.gov**
11.	**Inform** the patient there will be a formal investigation and that you will provide updates. Internally investigate how the event occurred. Here is an example of an investigation protocol: **https://www.ahrq.gov/patient-safety/settings/hospital/candor/modules/guide4.html.**

(related resource on back page)

CLOSED CLAIM STUDY

Excess C3F8 Gas During Pneumatic Retinopexy

RYAN M. BUCSI, VP, OMIC Claims

Allegation

Wrong concentration of gas during retinal detachment repair resulting in LP OD.

Disposition

Settlement of $1 Million.

The patient was referred from the emergency room to the insured who diagnosed a retinal tear and detachment OD. Advice for head positioning to minimize subretinal fluid accumulation was given and the patient was scheduled for pneumatic retinopexy in two days. During that follow-up visit, the insured noted that the patient had been compliant and the subretinal fluid was reduced over 50%. The insured performed a pneumatic retinopexy with C3F8 gas resulting in successful retinal adhesion. The gas bubble was to remain in the eye for several weeks.

The patient returned to the insured on postoperative day 1 and did not report any unexpected pain. Vision was CF at 1 foot and the IOP was 18. The retina was completely attached and there was a 70% gas fill. The patient called the next day complaining of increased eye pain and tears, which prompted the insured to prescribe Diamox and face down positioning to lower eye pressure.

The following day the insured saw the patient for severe pain and nausea. The patient's IOP was 73 with LP vision OD and a moderate amount of gas was released. The insured diagnosed acute angle closure glaucoma and 2 pressure checks were scheduled. The first check was 35 and the insured prescribed Cosopt BID in addition to the oral Diamox 250 mg QID. The second check was 24.

On the 6th postoperative day, the patient was experiencing severe pain. The IOP was 74 with NLP vision prompting another gas release procedure. The following day the patient reported pain, soreness, and very blurry vision. Visual acuity was HM at 6 inches and the IOP was 32. The anterior chamber was very shallow and the insured released gas from the back of the eye and injected a small mixture of sterile saline and gas into the anterior chamber to deepen it. Two days later, the patient reported pain OD. The visual acuity was HM at 1 foot with an IOP of 23. The technician reported the findings to the insured, who provided the patient with a referral to another ophthalmologist.

On the 11th postoperative day, another ophthalmologist noted that the patient felt more comfort OD, but expressed concern that the vision would not return. Visual acuity was HM at 6 inches and the IOP was 15. This ophthalmologist contacted the insured and they agreed to inject a gas bubble in the anterior chamber. The patient was instructed to return in 48 hours for a pressure check. The IOP on the subsequent check was 13.

Three days later, the patient reported a sharp feeling OD with itching and watering. VA was HM at 6 inches and the IOP was 11. The insured's examination revealed a swelling cataract, which was aggravating her glaucoma, and corneal edema. That evening, the insured performed a lensectomy and vitrectomy. The retina remained completely attached and the optic nerve normal.

On postoperative day 1, following the lensectomy and vitrectomy, visual acuity was HM at 1 foot and the IOP was <4. The insured noted that the cornea was clearing with a deep anterior chamber. There was no clear view of the retina or optic nerve due to the 80% gas bubble in the back of the eye.

Over the next 2 months the patient returned to the insured numerous times and the vision remained hand motion. The optic nerve was eventually visualized, but significant damage was noted. The patient did not return to the insured.

Analysis

Our experts main criticism was that the insured used double the amount of gas necessary which caused the patient's IOP to increase to 73 resulting in a complete loss of vision OD. The use of 2cc's of 100% C3F8 gas was indefensible and exceeded the normal capacity of the eye. This high IOP caused irreversible damage to the optic nerve in a short period of time (90 minutes). The experts had never seen a gas bubble of over 70% and could not support the care. As a result, the case was settled.

Takeaway

The operating surgeon is held responsible for any incorrect gas mixture and must confirm the concentration and amount of gas that is administered prior to surgery. These cases usually have devastating visual outcomes and often result in expensive settlements.

COMING SOON

A new and improved OMIC web site

We are pleased to announce that OMIC will be launching a new website in 2024. Our current site was introduced more than a decade ago in 2012 and has served us well; however we identified several areas that needed improvement. We have aimed to streamline content, improve searchability, and enhance features. We understand from the volume of page views, particularly for resources such as OMIC's sample patient consent documents, risk management recommendations, and practice protocol guides, that our site has become indispensable for our insureds' practices. Our goal is to display the information you need in an easy to find and logical way that helps you download the resource quickly and without complication.

Over many years, OMIC has budgeted significant financial and human resources for the production of risk management and patient safety materials, which has paid significant dividends, evidenced by our better-than-industry operating performance. We remain convinced that loss prevention through implementation of critical risk management protocols is one of the reasons OMIC continues to remain financially viable year after year.

Because the costs to develop our resources are borne by our policyholders, going forward, the materials available on OMIC.com will be available exclusively for insureds and will require sign-in for access by an OMIC-insured practice. We understand the sign-in process creates another step when accessing documents, so thank you in advance for your cooperation. We believe this is in the best interest of our policyholders.

OMIC's materials are copyrighted and therefore dissemination by any third party without prior permission is prohibited. When sharing OMIC's documents with another insured practice, we request that be accomplished by copying a url link to the location of the document on OMIC's site, rather than sharing the document itself, thereby ensuring access is by the intended audience with the appropriate credentials. Also, please contact OMIC if our materials are displayed in any other venue so that we may ensure that appropriate permissions have been granted.

Thank you for your support of OMIC and in keeping with our long-standing commitment to patient safety for the broader public, OMIC reserves the right to occassionally make certain resources available to the entire ophthalmic community when we deem appropriate and when there is a compelling public safety benefit.

New site infrastructure allows for additional features in the future

Another exciting reason for our website upgrades is to improve the architecture the site is built on. This will allow OMIC to introduce app features and offer device-friendly site performance as we know many of our insureds are accessing it through phones and tablets. Once our new site is up and running, look for many new related features in the years to come.

Your MyOMIC account

The best way to prepare for continuing easy access to OMIC.com resources will be to make sure you are registered with a MyOMIC profile. Make sure to enter your Client ID number in your profile (each insured physician and entity has a unique ID which is located on your policy documents). This will allow you access to all areas of the new website. Creating an account now will assist when completing forms, accessing information, requesting evidence of coverage, and other common activities online.

Update partner societies online

A significant change to our ophthalmic society partner program was implemented in 2023 and has resulted in our insureds accessing premium discounts more efficiently. Now that this process is self-directed, it is important that you maintain current information within your online profile to ensure that discounts are appropriately applied during 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 discounts is available per policy year.*

OMIC may periodically audit society membership to ensure proper application of the premium discount so please make sure that your current society memberships are always up-to-date at least 60 days prior to your coverage renewal.

CONTINUOUS QUALITY IMPROVEMENT

SIMPLIFY	Reduce the number of steps or handoffs required.
SAFEGUARD	Make it more difficult to bypass steps or create workarounds.
STANDARDIZE	Make it easier for staff to safely perform duties.
DOCUMENT	Implement written protocols and document to support compliance in the medical record; protocols should be in plain language and easily accessible to staff.
REPORT	Create a system for reporting errors and good catches; encourage staff to provide constructive feedback on protocols that are difficult to follow.
ANALYZE	Error and near-miss data help identify gaps in protocols and demonstrate what is working well and what needs to be improved.
DEVELOP	The above steps will be more successful within a **just culture** that values staff empowerment and a commitment to patient safety, and whose leaders model professionalism, respect, and transparency.

UPCOMING EVENTS

OMIC Bruce Spivey, MD, Forum

The popular OMIC Forum is scheduled for October 19, 2024 in Chicago, Illinois, during the American Academy of Ophthalmology's Annual Meeting.

Location: McCormick Place Convention Center, Room E-350

Topic: Lessons Learned From Glaucoma Claims (SYM17)

Time: 2:00 pm to 3:15 pm

AAO 2023 Annual Meeting

Please join us at the AAO Annual Meeting in Chicago. OMIC will be located in the exhibit hall next to the Academy Resource Center (at booth #2003). As in past years, we will offer a variety of OMIC courses and events. Please check the OMIC website calendar for more information.

Make sure to get your complimentary coffee drink at the OMIC booth! Stop by any time on Saturday, Oct. 19 and Sunday, Oct. 20, 9 a.m. to 1 p.m.

RESOURCES

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.

AAO store

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

Home study

Earn a 5% risk management discount by completing one of our online courses, made available exclusively to OMIC insureds.

Live seminars

Upcoming risk management presentations are posted regularly on our website.

Forms and Documents

We maintain a complete online library of forms, documents, and recommendations at OMIC.com.

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.