The Digest

Ophthalmic Mutual Insurance Company | Volume 36 | #1

A Ten-Year Review of OMIC Trial Outcomes Highlighting Risk Management Best Practices

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Often, we look at medical malpractice claims to focus on what went wrong and how we can glean lessons and risk management pearls. Defense verdicts can tell a different story; they offer insight into what a physician did correctly and how those actions can further guide our risk management best practices education.

A study conducted by the American Medical Association on medical liability claim frequency among U.S. physicians analyzed national data from 2016 to 2024 of both paid and unpaid claims, which included lawsuits. This study highlights that getting sued does not necessarily equal negligence: 65% of claims closed between 2016-2018 were not pursued or were dismissed. Six percent of claims from 2016-2024 went to trial and 89% of those resulted in defense verdicts. As of 2024, the proportion of physicians who were sued once in their career was 28.7%. The study broke down data of claim frequency by specialty. Physicians in surgical specialties faced the highest long-term risk of being sued with 46.5% being sued at least once in their career. For ophthalmologists, the percentage was lower than the average for surgical specialties at 27.6%.

In another study of paid malpractice claims reported to the National Practitioner Data Bank from 1999-2018, the most common allegations made in litigation were failure to diagnose, delay in diagnosis, wrong or misdiagnosis, and failure to order appropriate tests. This data includes all physician specialties. In the OMIC closed claim data from 2015-2025, the top allegations were surgery-focused (wrong surgery, informed consent issues, and improper performance) followed by failure to diagnose, and third was improper management of surgical patients. Improper management of surgical patients includes failure to recognize a complication, failure to refer, failure to diagnose, failure to follow-through, and failure to close the loop.

Across multiple defense verdicts from OMIC's ten years, successful outcomes consistently hinged on thorough documentation, effective communication, reasonable clinical rationale, and early recognition and management of complications. Juries focused on whether the physician's decisions were reasonable at the time care was rendered, whether complications were recognized and managed appropriately, and whether patients were adequately informed and engaged.

Between 2015 and 2025, a total of 42 OMIC cases were brought to trial. Of the 42, 33 resulted in defense verdicts and 3 resulted in a verdict for the plaintiff; 2 were settled during trial; and 4 were dismissed without payment during trial. The top 4 states for the number of cases taken to trial were CA, IL, PA, and FL. This summary provides a foundation for further analysis of verdicts and their implications for patient safety and risk management practices. We will begin with level-setting legal concepts in medical malpractice.

65%

OF CLAIMS CLOSED 2016–2018 WERE NOT PURSUED OR WERE DISMISSED

89%

OF CLAIMS THAT WENT TO TRIAL RESULTED IN DEFENSE VERDICTS

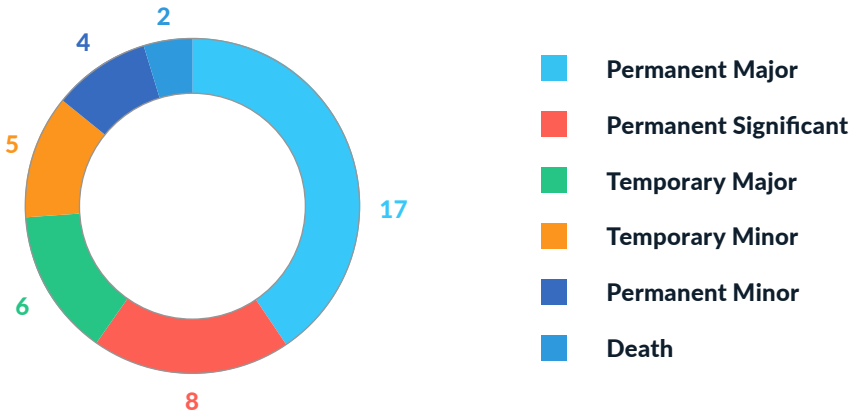
27.6%

OF OPHTHALMOLOGISTS SUED AT LEAST ONCE — BELOW THE SURGICAL AVERAGE

DISPOSITION	COUNT
Defense Verdict	33
Dismissed during trial (D win)	4
Plaintiff Verdict	3
Settled During Trial	2
TOTAL	**42**

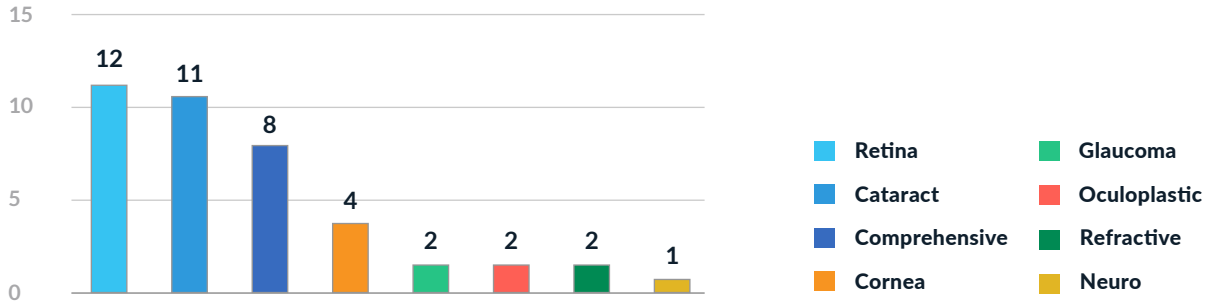
93% **defense win**
(37 of 40, excludes settled during trial)

Injury Severity



The injury severity distribution among cases taken to trial is heavily weighted toward more serious outcomes. Permanent Major injuries account for the largest share (17 cases), followed by Permanent Significant injuries (8 cases) and Temporary Major injuries (6 cases). Less severe categories are less common, with Temporary Minor injuries (5 cases) and Permanent Minor injuries (4 cases), while death is relatively rare (2 cases). Overall, the data show the majority of cases proceeding to trial involve high-severity, often permanent injuries, reinforcing that more serious patient outcomes are more likely to escalate to litigation and be pursued through trial, but can still be defended.

Specialty



The distribution of cases taken to trial shows that retina (12 cases) and cataract (11 cases) account for the largest share of litigation, together comprising over half of all trial cases. The third most frequent subspecialty was comprehensive ophthalmology with 8 cases. Other subspecialties appeared less frequently: cornea (4 cases); oculoplastic, glaucoma, and refractive surgery (2 cases each); and neuro-ophthalmology (1 case). Overall, the data suggest that higher-volume, procedure-driven specialties, particularly retina and cataract, are more commonly represented in trial cases, likely reflecting both procedural risk exposure and patient volume.

Retina had the most trials of all subspecialties. A series of retina-related cases involved high-severity injuries, complex surgical or medical treatment, and poor visual outcomes. Several patients underwent retinal detachment repair procedures, including pars plana vitrectomy and other retinal surgeries, which were followed by complications such as postoperative endophthalmitis, elevated intraocular pressure, recurrent detachments, additional surgeries, blindness, and in two cases eventual enucleation. Other cases involved delays in diagnosing or treating retinal detachment, central retinal artery occlusion (CRAO), or steroid-induced glaucoma, resulting in permanent vision loss. One patient developed blindness after postoperative endophthalmitis following cataract surgery, while another sustained globe perforation and vitreous hemorrhage during treatment of retinal holes after moving during a retrobulbar injection, resulting in permanent superior visual field loss. Overall, the cases illustrate recurring themes of retinal detachment management, postoperative infection, treatment delays, procedure-related complications, glaucoma-related vision loss, multiple surgical interventions, and severe outcomes ranging from permanent visual impairment to blindness and loss of the eye.

#	INJURY/CONDITION	TREATMENT	OUTCOME
1	**Retinal condition requiring vitrectomy**	**Pars plana vitrectomy**	**Postoperative endophthalmitis resulting in significant vision loss**
2	**Retinal detachment**	**Multiple retinal detachment repair procedures**	**Progressive complications ultimately requiring enucleation**
3	**Retinal detachment**	**Retinal detachment repair**	**Postoperative elevated IOP with subsequent permanent vision loss**
4	**Anterior uveitis**	**Steroid treatment; later diagnosed with orbital inflammatory syndrome**	**Disease progression and eventual enucleation**
5	**Retinal detachment**	**Retinal detachment repair and additional interventions**	**Painful eye/functional blindness**
6	**Retinal detachment and macular hole**	**Retinal detachment repair**	**Permanent vision loss**
7	**Cataract surgery referral to retina**	**Treatment following postoperative endophthalmitis**	**Blindness**
8	**Retinal detachment**	**Retinal detachment repair**	**Permanent vision loss**
9	**Central retinal artery occlusion**	**Sub-Tenon Kenalog injection resulting in artery occlusion**	**Permanent vision loss**
10	**Retinal disease requiring intravitreal steroids**	**Repeated steroid injections**	**Vision loss related to steroid induced glaucoma**
11	**Retinal holes OD**	**Laser retinopexy using retrobulbar anesthesia**	**Globe perforation after patient movement; vitreous hemorrhage; and permanent superior visual field loss**
12	**Retinal detachment**	**Pars plana vitrectomy**	**Postoperative endophthalmitis with significant vision loss**

Legal Concepts

STANDARD OF CARE

A complication during treatment does not necessarily mean there was negligence. In medical malpractice, the plaintiff must prove four key elements to establish negligence. First is duty of care, meaning a physician-patient relationship existed. Second is breach of that duty, meaning the physician failed to meet the applicable standard of care. This breach can be caused by an act or failure to act (omission). Third is causation, which requires a clear link between that breach and the patient's injury. Fourth is damages, meaning the patient suffered measurable harm. All four elements must be present for a case to succeed; if even one is missing, the plaintiff has failed to prove their case.

During litigation, each side obtains experts to make their case. Physicians' actions are measured against what a reasonably prudent physician with similar background and training would have done under similar circumstances. In some states they are also compared to physicians in the same or similar communities. Experts point to evidence-based guidance, specialty organization guidelines, community standards, and customs and practices to establish a basis for their opinions. Physicians should be able to justify their clinical decisions based on current science, evidence, and clinical reasoning that follow the generally accepted standard of care.

PREPONDERANCE OF EVIDENCE

In medical malpractice cases, the civil standard of proof is preponderance of the evidence, meaning the plaintiff must show that it is more likely than not (>50%) that negligence occurred. Unlike the criminal standard of "beyond a reasonable doubt," this lower threshold requires the jury to determine which side presents the more convincing and credible case. The plaintiff carries the burden of proving that the physician breached the standard of care and caused harm. For physicians, it is critical to understand that cases are often decided not solely on objective facts, but also on perception and credibility, particularly when expert opinions conflict and the jury must choose which side is more reasonable, credible, and convincing. In these situations, strong documentation, clear communication, and professional integrity can significantly influence how the evidence is weighed and may ultimately tip the scale in determining the outcome.

COMPARATIVE NEGLIGENCE

Comparative negligence is the legal principle that allows fault to be shared among multiple parties in a medical malpractice case, including the physician, other providers, the facility, and even the patient. Rather than assigning all fault to a single party, the jury apportions responsibility based on each party's relative contribution to the injury. There is variation across jurisdictions, but most states apply a modified comparative negligence system, in which each party is financially responsible for their percentage of fault. A plaintiff's recovery is reduced by their share of negligence and may be barred entirely if their fault reaches a specified threshold (typically 50% or 51%, depending on the state).

For example, a surgeon may be assigned fault for issues related to patient selection or informed consent, while an anesthesiologist may be assigned fault for failure to monitor or respond to cardiopulmonary events. A patient's recovery may also be reduced based on their own contribution, such as failure to follow postoperative instructions, delayed reporting of symptoms, or incomplete disclosure of medical history. From a risk management perspective, this reinforces the importance of clear communication, patient education, and thorough documentation, as these factors can significantly influence how fault is allocated in litigation.

CAPTAIN OF THE SHIP

The "captain of the ship" doctrine is an older, mostly outdated legal concept that held the surgeon responsible for everything that occurred in the operating room, regardless of who committed the error. The idea originated in an era when hospitals were largely immune from liability due to their status as charitable organizations. To counter this, courts imposed responsibility on the surgeon as the person in charge of the procedure. Under this theory, the surgeon was viewed as having control over all personnel in the OR, including nurses and anesthesia providers, and could be held liable for their negligence. Although the "captain of the ship" doctrine is still applied in CA, FL, NY, TX, GA, CO, and VA in varying degrees, most states today have moved away from this doctrine. Modern healthcare is recognized as a team-based environment, where each member of the team (or the person or entity that has control of the team members or systems) is held accountable for their own scope of practice. Instead of automatically assigning liability to the surgeon, courts now focus on concepts like comparative negligence, vicarious liability, and individual standards of care to determine responsibility.

VICARIOUS LIABILITY

Vicarious liability is a legal doctrine that holds one party, typically the employer or supervising physician, responsible for the negligent acts of another. This most often arises under the principle of respondeat superior, meaning "let the master answer." A hospital, surgery center, or medical practice can be held liable for the actions of the physicians and staff acting within the scope of their duties. A supervising physician can also be held liable for the acts or omissions of staff they supervise, as well.

The Data

In the cases that resulted in a verdict, there are clear, recurring themes in the case details that provide valuable lessons and reinforce risk management recommendations. These verdicts were not driven by perfect outcomes or flawless care. Many involved complications, dissatisfied patients, or unexpected clinical courses. The analysis further highlights that documentation and communication were the most frequently cited risk factors, with both appearing in 60% of cases, followed closely by issues related to follow-up care, informed consent, and management of complications, reinforcing that litigation risk is often driven by breakdowns in core practice processes rather than isolated clinical actions or decisions. Notably, even in cases involving severe injury, particularly permanent major injuries such as blindness, defense outcomes remained strong, suggesting that when physicians can demonstrate sound clinical judgment, appropriate management, and well-documented care, juries are more likely to find that the standard of care was met. Most cases involved multiple overlapping themes of documentation, communication, managing complications, informed consent, follow-up/continuity of care, and patient selection/clinical judgment, reinforcing that defense verdicts tend to reflect systems of practice rather than single actions. Informed consent could also be included under communication and documentation but belongs in its own category based on the importance and frequency of the allegation.

THEME	FREQUENCY	% OF CASES	THEME IN DEFENSIBILITY
Documentation	25	60%	Contemporaneous notes, clinical rationale, informed consent discussion
Communication	25	60%	Confirming comprehension with patients and staff, disclosure of complications, respectful response to patient concerns
Follow-Up / Continuity of Care	24	57%	Clear instructions, follow-up plans, addressing noncompliance, appropriate referrals/consults
Managing Complications	21	50%	Prompt recognition, appropriate response, referral/ escalation, continued involvement
Informed Consent	21	50%	Risks, benefits, and alternatives discussed and documented; setting expectations; procedure-specific consent form used; a process, not only a signature on a form
Patient Selection / Clinical Judgment	16	38%	Documentation of patient selection criteria, patient-specific risk factors, treatment limitations, decision to proceed or not and why

DOCUMENTATION

The medical record is a legal document that memorializes the patient's medical history, treatment rendered, recommendations, communication, and the clinician's medical decision-making and rationale. In the defense verdict cases reviewed, contemporaneous and consistent documentation was highly persuasive to jurors, particularly when it reinforced physician credibility and clearly articulated the clinical thought process. Documentation should reflect the story of care as it unfolds, not serve as a retrospective justification after an adverse event occurs. Complete and accurate records are also essential to support continuity of care.

Defensible documentation practices include establishing policies and procedures that promote consistency, accuracy, and credibility of the medical record. These should address expectations for contemporaneous documentation and timely finalization of notes (e.g., within 24–72 hours), as well as standardized informed consent documentation. The record should clearly reflect the physician's clinical reasoning and decision making, including the assessment, differential considerations, and rationale for treatment choices.

COMMUNICATION

Effective communication is essential to ensure patient understanding, adherence to treatment recommendations, and overall satisfaction with care. Breakdowns in communication can lead to confusion, dissatisfaction, and poor clinical outcomes. Low health literacy further underscores the importance of supplementing oral discussions with clear, written instructions, such as medication guidance, visit summaries, and

postoperative discharge instructions. In the defense verdict cases, documentation demonstrating consistent physician–patient communication was associated with stronger defense positioning. This included evidence of clear explanations of complications or unexpected outcomes, treatment recommendations, and follow-up plans; efforts by physicians to confirm patient comprehension; and ongoing engagement rather than abandonment. Conversely, when communication was not well documented or appeared insufficient, plaintiff arguments alleging "lack of concern" or "dismissiveness" were more difficult to refute, even when the clinical care itself was appropriate.

MANAGING COMPLICATIONS

Over half of the cases involved the management of complications. The determining factor was not that a complication occurred, but how it was handled, including the timeliness of recognizing the complication and how it was addressed, followed, and documented. Prompt and appropriate disclosure of an adverse event is critical and should be conducted with empathy, clear communication of the known facts, and a focus on next steps. From a risk management perspective, strong defense positioning was associated with early recognition and disclosure of the complication, an appropriate clinical response or referral when indicated, continued physician involvement in the patient's care, and thorough documentation of the care plan and patient discussions. When these elements were present, they demonstrated accountability, continuity, and patient-centered care, even in the setting of an adverse outcome.

INFORMED CONSENT

Informed consent was most persuasive when paired with adequate communication, documentation, and sound patient selection. The informed consent process includes an oral discussion, an assessment of the patient's comprehension and capacity to decide, and a written consent form disclosing the risks, benefits, and alternatives of the treatment, all of which should be documented in the patient's medical record. The consent process should cover specific risks related to the patient's medical history and background. It is recommended to have a consistent informed consent process which affirms it is the physician's non-delegable duty and not only a signature on a form. The purpose of informed consent is for patient autonomy, information, and education; setting expectations; strengthening the physician-patient relationship; and patient safety. When a patient refuses a recommendation, clearly documenting the refusal in the record and using an informed refusal form is highly encouraged. Lacking or inadequate informed consent is a frequent allegation in lawsuits and having a consistent process that follows risk management best practices is essential.

FOLLOW-UP AND CONTINUITY OF CARE

Twenty-four of the defense verdict cases reviewed involved allegations related to follow-up and continuity of care, including discharge instructions, documented follow-up plans, and physician response to noncompliance. In these cases, successful defense outcomes were strongly supported by evidence of reasonable physician involvement, clear expectations communicated to patients, and appropriate action when follow-up did not occur as planned. Continuity of care is especially critical when complications or unexpected events arise, as these patients warrant closer monitoring. Even when care is transitioned to another specialist, the referring physician should remain engaged, checking in with the patient to demonstrate concern and support, and ensuring appropriate coordination of care. This includes closing the loop on referrals and recommended testing. Failures in follow-up or continuity of care can result in missed or delayed diagnoses, delayed treatment, and gaps in care, which are more difficult to defend, even when the underlying clinical care was appropriate.

PATIENT SELECTION/CLINICAL JUDGMENT

Sixteen of the defense verdict cases involved allegations related to patient selection or clinical judgment. This includes patient selection criteria, recognition of risk factors, awareness of treatment limitations, and decisions regarding whether to proceed with a treatment or procedure. In these cases, successful defense outcomes were supported by documentation that clearly demonstrated thoughtful clinical reasoning, appropriate risk assessment, and treatment decisions based on the information available at the time of care. Strong documentation reflected not only why a patient was considered an appropriate candidate, but also how relevant risk factors specific to both the patient and the procedure were identified and considered. It further included clear discussions with the patient regarding treatment expectations, limitations, and available alternatives, as well as documentation of the physician's clinical judgment to proceed, defer, or modify treatment when indicated. When these elements were present, they reinforced that care decisions were credibly grounded in sound medical judgment, which was highly persuasive in demonstrating that the clinical decisions were reasonable, appropriate, and consistent with the applicable standard of care.

CONCLUSION

A comprehensive review of OMIC trial outcomes over a ten-year period highlights that defense verdicts are often driven not by the absence of complications, but by how well the physician can explain, document, and defend their clinical decisions. Across the cases analyzed, successful defense outcomes consistently reflected thorough documentation, reasonable clinical judgment, and effective communication, with juries focusing on whether the physician's decisions were sensible at the time care was delivered, and not simply on the outcome itself. Recurring risk management themes emerged, with most cases involving multiple overlapping factors rather than a single allegation of negligence. Notably, thorough, contemporaneous documentation that clearly articulated clinical reasoning, paired with evidence of ongoing patient engagement and appropriate responses to complications, proved highly persuasive in reinforcing physician credibility. These findings underscore that in litigation, defense success is often rooted in demonstrating a consistent and patient-centered approach to care, rather than perfection in clinical outcomes.

REFERENCES

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Message from the Chair

Robert G. Fante, MD, FACS
Chair, OMIC Board of Directors

A fire watchman's day in Colorado begins before the sun clears the timberline. The air in my beloved home state is dry – too dry again this year. Coffee in hand, binoculars scanning the horizon, radios crackling with quiet check-ins, fire prevention teams learn to read the land by subtle color changes, a faint column of smoke, wind direction telegraphed by the sway of grasses. Many have suffered loss from a fire themselves, and they are passionate about protecting others. Most days, nothing happens – and that is the goal.

Prevention is never passive – it is the result of vigilance – and modern fire monitoring is a complex and layered system that is rapidly changing. The watchful eyes described above are quickly being replaced with new technologies – only a few active fire towers remain. Today, aircraft patrol high-risk corridors. Ground crews install cameras and sensors in fire-prone zones. Satellites sweep the state for thermal anomalies, detecting heat signatures invisible to the human eye. Increasingly, AI systems will analyze satellite imagery to identify threats and prioritize a response before flames spread.

I am lucky to have friends among the firefighters. Despite these rapid tech changes, the men and women who watch for and fight fires are astonishingly devoted and zealous to protect their communities. They are humble and courageous at least partly because they have seen how heart-wrenching and devastating fires can be. Similarly, your OMIC team is remarkably dedicated, with decades of experience and talent working exclusively to protect and defend ophthalmologists and to help us provide our patients with the highest levels of medical care and accountability.

As I assume my role as leader of OMIC, I am committed to focusing our attention specifically on the joint work of liability claims prevention and aggressive, compassionate defense of our ophthalmologists whenever possible. As an oculofacial plastic surgeon for almost three decades in Denver, I've seen my share of scary near-misses in my own practice, and I have learned a great deal in my 12+ years with OMIC's committees. I remember how anxious and frightened I was the first time an attorney demanded records many years ago. I love the idea that we could

Message from the chair

perhaps prevent almost all malpractice litigation by engaging OMIC's resources in finding new ways to rapidly resolve claims, and by engaging OMIC's 6,500+ physicians in conscientious endeavors to manage risk and prevent trouble. Everyone would be better off. Early detection and rapid response are critical to mitigating fire danger. They're also key to our avoidance of poor medical outcomes and malpractice litigation. Likewise, OMIC's early sympathetic peer-specialist analysis of claims can lead to better resolutions that protect doctors and patients. We are indeed fortunate that we are members of this risk retention group that looks out for us.

Subtle documentation gaps or communication breakdowns are early warning signs for future exposure to malpractice claims. Think of them as the faint plume in the distance signaling danger. Increasingly, our practice of ophthalmology is becoming reliant on emerging technologies similar to professions such as firefighting. These advances offer incredible opportunities but must be carefully implemented with an eye toward risk prevention. Our teams must review and standardize informed consent materials, strengthen triage and follow-up procedures,

> “ Subtle documentation gaps or communication breakdowns are early warning signs for future exposure to malpractice claims.

and create ever-better resources for our insured physicians. Instead of satellites, sensors, and observers, we as practitioners must rely on ongoing risk management engagement, protocols, peer consultation and review, and attention to scientific progress. Together with the AAO, OMIC established the Bruce E. Spivey, MD, Fund for Risk Management Studies that actively searches for correctable trends in ophthalmology that could signal current and future reductions in risk, patient safety, and liability. As Spivey Fund researchers capitalize on the incredible resources of the IRIS registry, we expect many insights that will help physicians practice more safely and successfully.

I encourage you to call OMIC's risk management hotline at the first hint of trouble. I've called them many times with a rapid pulse myself and consequently felt more confident, informed, and less exposed. This service from OMIC is critical and our staff is uniquely able to provide a rapid response. Some patient outcomes and external legal environments remain beyond our control. Like trying to manage the weather to prevent fires, it would be impossible to achieve this as a goal. But we do have more control over our circumstances than we often realize. The importance of quick action when “smoke” is detected is essential, regardless of how faint the plume may appear, because a fire contained at 10 acres is a footnote; at 10,000 acres, it is a headline. When a complication or a claim arises, coordinated and timely action helps determine whether it escalates or resolves.

As Chair of OMIC, I see our company's first role much like that of the watchman, standing on the ridgeline, surveying the landscape and acting decisively when threats appear. Technology will allow us new ways to protect you, while the same basic principles remain relevant and true. Stay vigilant and prepared.

I see the following areas of focus on our proximate horizon:

- **Identify and communicate emerging medical and legal risks clearly with specific focus and emphasis on early response.**
- **Search for systems that can resolve simpler claims with reduced involvement of lawyers and courts.**
- **Understand the changing characteristics of ophthalmic practice and adjust coverage with innovative solutions for solo and group practices of various sizes.**
- **Build resilience into our systems as well as policyholder and patient education resources, with layers of firewalls, rather than simple compliance in mind.**
- **Foster confidence with transparent governance, responsiveness to insureds, and buttressed with high expectations for service.**

From the “watchtower,” OMIC's goal will be quiet days – no smoke, no alarms, just vigilance rewarded by tranquility. That is the future we aim to build together: one where risk is managed so well that it rarely announces itself. Although OMIC also fights the fires when needed in this analogy, it is best for everyone to prevent and to act early and decisively.

And like the watchman, we must never mistake quiet for safety - it is the result of our discipline and dedication to the “work” of prevention.