Risk Management in Ophthalmology: Legal Overview

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SUNY Downstate
Atlantic City, NJ, January 2014
Legal Context in the US

• US and State Constitutions
• Federal legislation and regulations
• State legislation and regulations

• Case law
  – Precedents in case law
  – Interpretation of legislation and regulations
Basics of Malpractice

• State by state rules and standards
  – Traditionally, set by court decisions
  – Increasingly, state legislative involvement

• Four essential elements
  – Duty: Doctor – patient relationship
  – Breach of standard of care (target pressure)
  – Proximately causes (“but for”)
  – Actionable damage to patient (vision loss)
When is a Duty Established?

- Advice over telephone, even if never seen
- Certainly, after a patient is seen
- Possibly, after an appointment has been scheduled
Breach of Duty Occurs When Not Provide Adequate Care

• Standard of care varies
  – State case law
  – Comprehensive vs. specialist
  – Statutory and regulatory

• “Vicarious” liability – for your employees and staff
Breach Must “Cause” an “Injury” Under the Law

- Loss of vision
- Economic damages
- Emotional trauma
- Pain or other suffering
Relationship between injuries & claims
(Pooled Data) (Courtesy of Michelle Mello, PhD, JD)

- All Hospitalizations
  - Injuries due to medical care (≈3–4%)
  - Due to substandard care (≈1%)

- “Valid” Potential Claims
  - Actual claims (≈2% of potential)

- “Valid” Claims
  - ~20% of claims are “valid”

- “Frivolous” Claims

- Paid Claims
  - ~30% of claims are paid


Procedural Steps

- Plaintiff’s attorney reviews records
- Filing of notice of claim / claim
- Panel review or arbitration (if required)
- Discovery via documents and depositions
- Negotiations
- Trial
- Verdict
- Appeals
### Closed Paid Claims – Florida 1991-2003


<table>
<thead>
<tr>
<th>Stage of Claim</th>
<th>Percent</th>
<th>Mean $</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presuit period</td>
<td>20</td>
<td>147 K</td>
</tr>
<tr>
<td>After arbitration</td>
<td>6</td>
<td>174 K</td>
</tr>
<tr>
<td>After suit</td>
<td>69</td>
<td>258 K</td>
</tr>
<tr>
<td>Pre-verdict trial</td>
<td>2</td>
<td>454 K</td>
</tr>
<tr>
<td>After trial verdict</td>
<td>2</td>
<td>higher</td>
</tr>
</tbody>
</table>
Paid Claims in Florida
Of cases in 1981, closed in 1994, eye MD’s:

- 3% of total liability claims
- 33% of claims settled with payment
- 15% of ophthalmologists involved in claims
## OMIC and PIAA Ophthalmology Claims over 17 years

(Courtesy of Anne Menke, RN, PhD; OMIC Risk Manager)

<table>
<thead>
<tr>
<th></th>
<th>OMIC</th>
<th>PIAA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Closed Eye Claims</td>
<td>1663</td>
<td>5556</td>
</tr>
<tr>
<td>Total Paid Claims</td>
<td>21%</td>
<td>29%</td>
</tr>
<tr>
<td>Avg Indemnity Paid</td>
<td>$130,112</td>
<td>$164,905</td>
</tr>
<tr>
<td>Expenses Paid</td>
<td>$ 37,667</td>
<td>$ 26,693</td>
</tr>
<tr>
<td>Avg Exp w/o Indemnity Paid</td>
<td>$ 11,329</td>
<td>$ 11,884</td>
</tr>
</tbody>
</table>
Principal Allegation: Glaucoma Malpractice Claims
(Courtesy of Anne Menke, RN, PhD; OMIC Risk Manager)

• Surgical Misadventure 24%
• Failure to Diagnosis 17%
• Improper Medical Management 13%
• Medication Errors 7%
• Surgery not Warranted 7%
• Failure/Delay in Consultation 5%
• Surgery not Performed 4%
• Failure to Instruct/Communicate 3%
Associated Allegations: Glaucoma Malpractice Claims
(Courtesy of Anne Menke, RN, PhD; OMIC Risk Manager)

- Problem with Records/Billing 23%
- Consent Issues/Breach of Contract 12%
- Vicarious Liability 11%
- Poor Compliance 5%
- Lack of equipment or malfunction 4%
- Abandonment 3%
Range of Losses — Largest and Median

Courtesy of Anne Menke, RN, PhD; OMIC Risk Manager

$1.8 million

Largest Loss

$90,000

Median Loss
Keys to Avoiding Malpractice Liability

• Adequate quality care

• Communications

• Documentation
Keys in Communications

- Don’t assume, ask
- Listen and pay attention
- Acknowledge
- Understand lack of comprehension
Cumulative Distribution of Physician Cohort Members and Unsolicited Complaints

Complaints and Risk Management
Hickson, et al, JAMA, 2002

<table>
<thead>
<tr>
<th>No. of RMF Openings</th>
<th>Unsolicited Patient Complaints, No. (%)</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0-1</td>
<td>2-6</td>
<td>7-14</td>
<td>15-24</td>
<td>25</td>
<td>Total</td>
</tr>
<tr>
<td>0</td>
<td>223 (35)</td>
<td>92 (14)</td>
<td>44 (7)</td>
<td>9 (1)</td>
<td>3 (1)</td>
<td>371 (58)</td>
</tr>
<tr>
<td>1</td>
<td>38 (6)</td>
<td>38 (6)</td>
<td>27 (4)</td>
<td>13 (2)</td>
<td>6 (1)</td>
<td>122 (19)</td>
</tr>
<tr>
<td>2</td>
<td>9 (1)</td>
<td>17 (3)</td>
<td>13 (2)</td>
<td>14 (2)</td>
<td>11 (2)</td>
<td>64 (10)</td>
</tr>
<tr>
<td>≥3</td>
<td>6 (1)</td>
<td>13 (2)</td>
<td>12 (2)</td>
<td>21 (3)</td>
<td>36 (6)</td>
<td>88 (14)</td>
</tr>
<tr>
<td>Total</td>
<td>276 (43)</td>
<td>160 (25)</td>
<td>96 (15)</td>
<td>57 (8)</td>
<td>56 (10)</td>
<td>645 (100)</td>
</tr>
</tbody>
</table>

*χ² = 274; P < .001.
## Complaints and Malpractice

Hickson et al, JAMA, 2002

### Table 3. Results of Logistic Regression Analysis to Assess Association Between Risk Management Outcomes (Dependent Variables) and Specialty Group, Complaint Count, Clinical Activity, and Sex (Explanatory Variables)

<table>
<thead>
<tr>
<th>Dependent Variable and Specialty Group</th>
<th>No. of Physicians With Each Dependent Variable (N = 645)</th>
<th>Wald $\chi^2$ for Explanatory (Predictor) Variables</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Specialty Group</td>
<td>Complaint Count</td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>-----------------</td>
<td>-----------------</td>
</tr>
<tr>
<td><strong>Risk management files (RMFs)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All physicians</td>
<td>274</td>
<td>20.0 &lt;.001</td>
</tr>
<tr>
<td>Nonsurgeons</td>
<td>137</td>
<td>15.1 &lt;.001</td>
</tr>
<tr>
<td>Surgeons</td>
<td>137</td>
<td>11.8 &lt;.001</td>
</tr>
<tr>
<td><strong>RMFs with expenses</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All physicians</td>
<td>192</td>
<td>31.1 &lt;.001</td>
</tr>
<tr>
<td>Nonsurgeons</td>
<td>81</td>
<td>2.3 .13</td>
</tr>
<tr>
<td>Surgeons</td>
<td>111</td>
<td>10.3 &lt;.001</td>
</tr>
<tr>
<td><strong>At least 1 lawsuit</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All physicians</td>
<td>139</td>
<td>16.4 &lt;.001</td>
</tr>
<tr>
<td>Nonsurgeons</td>
<td>57</td>
<td>0.3 .58</td>
</tr>
<tr>
<td>Surgeons</td>
<td>82</td>
<td>12.5 &lt;.001</td>
</tr>
<tr>
<td><strong>Multiple lawsuits</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All physicians</td>
<td>43</td>
<td>14.8 &lt;.001</td>
</tr>
<tr>
<td>Nonsurgeons</td>
<td>8</td>
<td>0.3 .58</td>
</tr>
<tr>
<td>Surgeons</td>
<td>35</td>
<td>17.6 &lt;.001</td>
</tr>
</tbody>
</table>

*Probability that the explanatory model correctly classifies each type of risk management activity.
Communicating Bad Outcomes

• Maloccurrence not the same as malpractice

• Prior informed consent and education

• Honest communications of situation
  – Disclose complications
  – Apology movement gaining momentum

• See the patient as often as needed

• Communicate with partners on call

• Second opinion / referral

• Careful co-management
Summary / Conclusions

- Malpractice claims in ophthalmology are relatively uncommon among all medical specialties
  - Surgical misadventure
  - Misdiagnosis
  - Compounded by documentation / billing issues
- Less than a third are closed with payment
- Paid claims are settled prior to trial verdict (> 90%)
- Avoid claims by **communications** with patient and family members
Claims Involving Glaucoma

- Kraushar & Robb, 1996
  - 15% of eye claims
  - 13% of costs
  - Negligent diagnosis (all)

- Bettman, 1990
  - 8% of eye claims
  - Negligent diagnosis (44% primary)
Malpractice in Glaucoma

- Van Buskirk, Survey 1996
  - Failure to diagnose or note progression
  - Complications of tx
  - Iatrogenic glaucoma
  - Beyond skill of MD

- Craven, Survey 1996
  - Review of 194 cases
  - Half paid
  - 20% higher payout than average eye case
GLAUCOMA AS % OF CLAIMS

(Based upon OMIC-PIAA-Jury Verdicts)

92%
8%
**Influence on Choice of MD’s**

*Kaiser/AHCPR 10/96*

<table>
<thead>
<tr>
<th>Factor</th>
<th>A lot</th>
<th>Some</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communications skills</td>
<td>84%</td>
<td>12%</td>
</tr>
<tr>
<td>Board-certified</td>
<td>71</td>
<td>20</td>
</tr>
<tr>
<td>On health insurance plan</td>
<td>49</td>
<td>31</td>
</tr>
<tr>
<td>Privileges at given hospital</td>
<td>38</td>
<td>36</td>
</tr>
<tr>
<td>Years in practice</td>
<td>35</td>
<td>41</td>
</tr>
<tr>
<td>Office close to patient</td>
<td>35</td>
<td>35</td>
</tr>
</tbody>
</table>
Documenting “No-Shows”

- Document “no show” and follow-up phone call or letter
- If serious condition or multiple no-shows, send return receipt / registered letter and file in chart
- Withdraw if continued noncompliance or if circumstances warrant
“It wasn’t done if it wasn’t documented … “

• Note ALL phone calls
  – Who and what at a minimum
  – AND office response
  – AND file in patient’s chart

• Record all phone calls regarding lab results and advice in chart
Documenting Billing and Non-Care Related Disputes

• Do NOT put billing / financial or any non-clinical care disputes in medical chart

• When patients angry or hostile, document what happened without judgmental or emotional terms (use “appeared angry, shouted at staff” instead of “stupid”)