Spring 2007 Volume 17 Number 2 OPHTHALMIC MUTUAL INSURANCE COMPANY

Ophthalmic Risk Management Digest

OMIC DIGEST

Honesty the Best Policy When Things Don't Go Well

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Faced with a medical error, patients want their doctor to do three things: explain what happened, say he or she is sorry that the patient experienced the poor outcome, and assure the patient that steps will be taken to prevent the same thing from happening to others.[1] While many physicians want to talk to their patients in this way about errors and other adverse events, they may hesitate to do so for a variety of reasons. Some fear that disclosing errors and complications may prompt a lawsuit. Others may lack the communication skills necessary to respond to a patient's anger and grief with compassion rather than defensiveness. When other health care providers or organizations are involved, some physicians may feel conflicting loyalties or be concerned about the impact of a disclosure discussion on collegial relationships, referral patterns, or credentialing.

Ophthalmologists calling OMIC's Risk Management Hotline frequently ask for advice about revealing errors, offering apologies, or waiving fees. OMIC's approach is founded on the principles of honesty, compassion, and fairness to both the ophthalmologist and the patient, and is designed to help minimize the risk and severity of claims and lawsuits. Over the years, articles in *Argus* (now published by the American Academy of Ophthalmology as *EyeNet*) and the *OMIC Digest* have offered advice on this topic. Dr. Jerome Bettman noted that "when complications arise, honesty is the best policy." He encouraged physicians to "tell the patient what has happened as soon as possible." Dr. Byron Demorest advised that "waiving your bill may avert a claim following a poor clinical outcome." Paul Weber, vice president of OMIC's Risk Management/Legal Department, reminded insureds, "don't be afraid to say you're sorry."[2]

OMIC's claims experience indicates that whatever the event or situation, communicating with the patient or patient's family about the adverse outcome sympathetically and non-defensively within the shortest appropriate time period may

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MESSAGE FROM THE CHAIRMAN

This October will mark 20 years since the American Academy of Ophthalmology challenged the traditional insurance industry and launched the first and only professional liability insurance carrier exclusively for ophthalmologists. From a fledgling start-up risk retention group in 1987, the Ophthalmic Mutual Insurance Company has become one of the nation's most respected medical liability carriers as well as the Academy's most successful sponsored program. OMIC has long been recognized as the industry leader in ophthalmic underwriting, claims defense, and risk management, and we are one of the few liability carriers to post positive year-end earnings every year that we have been in business.

Last year was OMIC's most successful year of operation. Our year-end 2006 financial results will be recognized as a significant accomplishment throughout the industry and among our peers. OMIC's financial ratios improved steadily in recent years because the board and management took the necessary, and sometimes difficult, steps to meet our financial obligations to a larger insured base and achieve the favorable ratios used by rating agencies to measure an insurer's financial health.

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help dispel much of the patient's anger, confusion, and distrust. A patient's belief that he or she is not being told the whole story, or is not being given the opportunity to ask the physician questions and vent feelings, often provokes a decision to seek the advice of an attorney and pursue a medical malpractice claim against the ophthalmologist. Indeed, studies have shown that patients who sued their physician often did so because their doctor did not help them understand what happened.

Patients who experience unanticipated outcomes are often confused about the difference between a poor or unsatisfactory outcome—a maloccurrence—and malpractice. An unanticipated outcome may or may not be the result of error or negligence, and not all errors are the result of medical malpractice. In fact, further investigation into an unanticipated outcome or allegation of negligence may reveal that what initially appeared to be malpractice was actually the result of the disease process itself or an unforeseeable or unpreventable complication of a risky, or even life- or vision-saving, treatment. To assist policyholders in dealing with patients following unanticipated outcomes, OMIC offers confidential, individual counseling through our Risk Management Hotline at (800) 562-6642, ext. 651. During these conversations, we help the ophthalmologist prepare for disclosure discussions, conduct an event analysis to evaluate the causes of unanticipated outcomes and improve patient outcomes in the future, respond to complaints, and weigh options when faced with a request for a refund. OMIC's detailed recommendations on "Responding to Unanticipated Outcomes" are available as a document from our web site and are applied to case studies in two presentation formats, a CD and online course. This issue of the *Digest* illustrates many of these approaches. This article presents how an error, a complication, and unmet expectations were handled by three OMIC policyholders. **Policy Issues** discusses apologies in relation to OMIC's policy coverage; the **Closed Claim Study** examines fee waivers; and the **Hotline** discusses waivers, refunds, and indemnity payments.

"Taking the High Road" When an Error Occurs

A 44-year-old man presented for bilateral LASIK correction of hyperopia. The next day, he reported significant visual difficulties, which examination revealed were due to high hyperopia and astigmatism. The ophthalmologist explained that the results were not what he expected. He told the patient he wanted to review the records and asked the patient to return the next day. The ophthalmologist contacted OMIC when he discovered that the patient had been treated with another patient's laser settings. The physician explained that the first patient of the day had cancelled his surgery and that the second patient did not correct staff members when they repeatedly called him by the other patient's name.

The ophthalmologist planned to tell the patient what had happened and provide treatment to address his visual difficulties at no charge. We agreed with his approach. After unsuccessful trials of contact lens and glasses, the patient underwent refractive lens exchange with implantation of a toric lens, followed by bilateral LASIK to treat residual refractive error, all at no charge to the patient. While his UCVA was 20/20 on the first postoperative day, his vision quality later deteriorated. At that point, the patient not only stopped seeing the surgeon, but sought legal advice.

An independent medical examination confirmed central irregular astigmatism that could not be corrected surgically, and BCVA of 20/80 OD and 20/100 OS. The ophthalmologist was disheartened that an error had harmed his patient but remained proud of "taking the high road" to stand by his patient and develop better patient identification policies. His honest, compassionate response was acknowledged by the plaintiff and his attorney. The case was settled for $85,000 on his behalf; the refractive surgery center paid $15,000.

Failure to Disclose Is Difficult to Defend

As sometimes happens in cataract surgery, a tear occurred in the posterior capsule, allowing a small fragment to drop into the posterior chamber. The ophthalmologist performed a minimal anterior vitrectomy and proceeded to place the IOL in the posterior chamber. Postoperative visual acuity was 20/100, with the IOP elevated at 30. The surgeon prescribed anti-inflammatory, antibiotic, and pressure-lowering drops. Over the next ten months, the IOP fluctuated from a low of 18 to a high of 38, with VA progressively declining to LP. On the last visit, the patient expressed her unhappiness about the outcome and promised to seek a second opinion.

The patient was true to her word and ultimately filed a lawsuit, during which she learned for the first time of the intraoperative complication. Defense and plaintiff experts agreed that the surgery was indicated and that the complication itself was evidence of a maloccurrence rather than malpractice. Unfortunately for both the ophthalmologist and the patient, they also concurred

in their criticism of the surgeon for neither documenting nor disclosing the complication. Furthermore, they noted that the postoperative management was negligent in that no effort was made to find or remove the lost fragment, despite ongoing problems with elevated intraocular pressure and decreasing visual acuity. They felt that an early referral to a retinal specialist could have resulted in a better outcome for the patient. The policyholder agreed, and the patient was compensated $200,000.

As this case demonstrates, physicians are often reluctant to inform patients of complications, but patients clearly want to be told. Indeed, one study showed that 98% of patients want to be informed of even a minor error, and the more severe the outcome, the more patients and families desire information. While 92% of patients thought they should always be told about complications, only 60% of physicians thought so. Similarly, 81% of patients said they wanted to know about future adverse outcomes associated with complications, but only 33% of physicians thought patients should be told about such adverse outcomes.[3]

OMIC policyholders who are unsure about whether and how to disclose an adverse event to a patient can discuss the matter with our risk management specialists. Had OMIC been consulted in this situation, we would have encouraged the ophthalmologist to approach the patient at her postoperative visit with the following information: "Mrs. Jones, as you noticed, your vision is not what you and I expected, and your eye pressure is high today. Yesterday, there were some problems during the surgery. Part of your lens fell into the back of your eye. If I had removed it, your eye could have been injured. I am putting you on some drops to control the pressure and swelling and prevent an infection. I'll watch your eye closely. If the pressure doesn't come down, or your vision doesn't improve, I'll want you to see a retina specialist who may need to remove the piece of lens. I'm so sorry this has happened to you. I'm going to do all I can to help you deal with this complication and protect your vision. Do you have any questions?" Such a discussion will not only strengthen the physician-patient relationship and help involve the patient in his or her care, but can also prevent an allegation of fraudulent concealment, which could open the door to punitive damages.

Some Patient Expectations Cannot Be Met

A 65-year-old presented to an ophthalmologist with a complaint of droopy upper eyelids. Examination revealed bilateral ptosis and mechanical upper eyelid entropion. After a detailed informed consent discussion, the patient agreed to a bilateral upper lid blepharoplasty and internal ptosis repair. The surgeon was pleased with the outcome; the patient was not. As she put it, she "missed the face she was born with." The ophthalmologist responded with patience and compassion as the patient continued to express her discontent. When she wrote a letter threatening a lawsuit and complaint to the Centers for Medicare and Medicaid (CMS) if he did not pay for surgery by another ophthalmologist, the insured called OMIC for assistance. He was disappointed that the patient was unhappy but felt he had provided the best possible care. We agreed with his decision to deny her request and helped him craft a letter in which he stated that while he was sorry she continued to be unhappy about her outcome and the fact that surgery had not met her expectations, he was unwilling to pay for additional consultations or treatment. In response to the patient's claim letter, OMIC had the case reviewed by an oculoplastics specialist, who felt the surgeon had provided excellent care. The patient's complaint to CMS was similarly dismissed and the patient never filed a lawsuit.

Two of the ophthalmologists discussed in this article had frank but empathetic conversations with their patients about the unanticipated outcomes, while the third chose not to document or disclose the complication. All three received written patient complaints or demands for money, two of which resulted in indemnity payments. Talking to patients in a forthright manner will not necessarily prevent claims and lawsuits, but it will help physicians feel they have responded with dignity and professionalism, in accordance with the ethical standards of the American Academy of Ophthalmology and the American Medical Association. Such an approach can also decrease the amount the physician may need to pay to compensate the patient if compensation is warranted.

1. Vincent C, Young M, Phillips A, "Why do patients sue doctors? A study of patients and relatives taking legal action," *The Lancet*, 1994; 343: 1609-13.

2. Bettman, Jerome W, Sr, MD, "When Complications Arise, Honesty is the Best Policy," *Argus*, May 1992. Demorest, Byron H, MD, "Waiving Your Bill May Avert a Claim Following a Poor Clinical Outcome," *Argus*, Nov 1992. Weber, Paul, JD, "Don't Be Afraid to Say You're Sorry," *OMIC Digest*, Spring 2001.

3. American Society for Healthcare Risk Management (ASHRM), "Disclosure of unanticipated outcomes: The next step in better communication with patients (first of three parts)," May 2003. ASHRM web site, www.ashrm.org, accessed September 2004.