

Ophthalmic Risk Management Digest

OMIC DIGEST

MESSAGE FROM THE CHAIRMAN



Malpractice insurance premiums are a significant overhead expense for most ophthalmic practices, and no one understands this better than the practicing ophthalmologists on OMIC's Board of Directors. As stewards of OMIC, it is the Board's intention to always return any premium that is above the level required to maintain the company's solid long-term financial position. In light of OMIC's favorable claims experience and strong financial results, the Board declared a policyholder dividend in 2006 and a rate decrease in 2007. This year, I am very pleased to announce that we will again be reducing the cost of malpractice insurance for all OMIC policyholders. Effective January 1, 2008, OMIC's annual base premium rate will decrease by an average of 7.2%, depending on each state's specific loss experience. Furthermore, insureds will save an additional 11% in the form of a dividend credit applied to their renewal premium. As a result of these rate decreases and paid dividends by OMIC over the last three years, overall malpractice costs for our policyholders have decreased by 27.5% or \$12.5 million.

When setting premium rates each year, the company's officers and directors must ensure that

continued on page 2

My Doctor Never Told Me That Could Happen

By Anne M. Menke, RN, PhD

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Why do patients sue? This question, pondered by most physicians at some point in their careers, prompted a famous study that was published in JAMA in 1992. GB Hickson and his co-authors queried obstetrical patients who filed lawsuits after their infant had experienced permanent injuries or death. The study showed that patients initiated malpractice claims, in descending order of frequency, when they were advised to sue by a knowledgeable acquaintance (often a physician), needed money, believed there was a cover-up, felt their child would have no future, wanted more information, or wanted revenge or to protect others.¹ This article will explore physician-patient communication with particular focus on how to use the informed consent process to keep the lines of communication open before and after surgical procedures.

The insurance industry has long known that the majority of claims involve a relatively small number of physicians. The Hickson study authors wondered why. Do these high risk physicians attract higher risk patients? Do they practice bad medicine? Or do they relate differently with patients? In order to explore the relationship between physicians' malpractice experience and their patients' satisfaction, the authors devised a new study and asked a different group of mothers about their satisfaction with pregnancy and delivery care (see Table 1).²

TABLE 1

PHYSICIAN CLAIMS HISTORY AND PATIENT DISSATISFACTION

AREAS OF CONCERN	PATIENT COMPLAINTS		
	0	1-3	≥3
PRIOR CLAIMS	0	1-3	≥3
Communication	8	18	27*
Care/Treatment	5	15	22*
Access/Availability	7	11	15*
Humaneness of MD	5	6	17*

*statistically significant

continued on page 4

IN THIS ISSUE

- 2** [Eye on OMIC](#)
OMIC Makes Consent Forms More Physician-Friendly
- 3** [Policy Issues](#)
Who Can I Talk To?
- 6** [Closed Claim Study](#)
Off-Label Use of ICG Dye During Vitrectomy for Floaters
- 7** [Risk Management Hotline](#)
Obtaining Consent on the Day of Surgery
- 8** [Calendar of Events](#)
Online Courses, CD Recordings, Upcoming Seminars

My Doctor Never Told Me That Could Happen

continued from page 1

The results confirmed the authors' hypothesis that lawsuit frequency correlates with the volume of patient complaints about interpersonal aspects of care. Physicians with no claims history were perceived as "concerned, accessible, and willing to communicate," whereas those with multiple claims were viewed as "hurried, uninterested, and unwilling to listen and answer questions." In a companion article that examined quality of clinical care, SS Entmann et al found no correlation between prior malpractice history and either objective or subjective measures of quality of care.³ This supports the Hickson findings that factors other than bad medicine are to blame for lawsuit frequency.

The central role that provider-patient rapport plays in malpractice claims was also supported by a 1994 finding by HB Beckman et al that a breakdown in patient-physician communications could be associated with over 70% of professional liability litigation.⁴ Patients would rather not sue their physicians. Vincent et al note that they want their doctor to do three things after a poor outcome: 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 other patients.⁵

Risk management experts have suggested that much of this communication dysfunction could be avoided by engaging the patient and family in a constructive, ongoing informed consent dialogue designed to invite them to participate in their care, clarify misconceptions, and minimize unrealistic patient expectations. Rather than being a purely legal function that must be fulfilled prior to invasive procedures, consent becomes an opportunity to establish a "therapeutic alliance" between the ophthalmologist and the patient wherein each acknowledges the

clinical uncertainties that exist to some degree with each medical or surgical intervention.⁶ As the next section shows, forging such an alliance takes careful consideration and thoughtful communication.

What Do Patients Want?

Weighing the risks and benefits of a proposed surgery is central to the informed consent process and begins with understanding what the patient wants from surgery. CK Pager's Expectations and Outcomes in Cataract Surgery (EOCS) study analyzed preoperative expectations about outcomes and studied what led to patient satisfaction.⁷ After an informed consent discussion, patients completed the Visual Function Index, known as the VF-14, and indicated what they felt their score would be after surgery. Expectations ran "unreasonably high" in the patients in this 2004 study. They anticipated achieving a mean VF-14 score of 96.1 (an 11 point gain), and fully 60% assumed they would achieve a perfect score of 100 postoperatively.

One might expect satisfaction to correlate with improvement in VF or the actual outcome. Instead, patients weren't satisfied unless they got what they expected, and those with an ocular comorbidity were most likely to be dissatisfied. When patients had expectations of reading small print, doing fine handiwork, reading a newspaper, or driving at night, they were decidedly unhappy if they had difficulty performing these tasks postoperatively. Indeed, few patients realistically achieved their goal, leading Pager to conclude that 70-year-old patients expect cataract surgery to enable them to see like 20-year-olds. Given the current advertising about the benefits of "multifocal" and "premium" IOLs, it is worth noting that these unrealistic patients all had monofocal implants, and had not been subjected to advertising promising them full

recovery of their youthful vision. The only suggestion the study offered was to use the informed consent process to contribute to more accurate patient expectations.

What Do Patients Hear?

What do patients hear and understand about risk during an informed consent discussion? More pointedly, if patients expect perfect vision, how can ophthalmologists prepare them to accept not only realistic outcomes but possible complications? Unfortunately, just as prospective patients overestimate the benefits of cataract surgery, they underestimate the risks.⁸ In a study by CG Kiss et al, patients were provided with a standardized informed consent document that fully explained the risks, benefits, and alternatives. When questioned after the consent discussion, patients nonetheless believed that cataract surgery was relatively easy. Fully 76% felt there was no risk of a complication; when pressed, 60% maintained that even in their own surgery, there was no risk of a severe complication. Even when they finally admitted that the risk of a severe vision-threatening complication was real, 77% did not take risk into account when making the decision to proceed with surgery. Indeed, 78% said that the discussion had no impact on their decision, while the rest reported that it only confirmed the choice they had already made.

What frustrates ophthalmologists and healthcare risk managers is that these same patients may well claim in court that the discussion never took place or that they never would have consented to the surgery if informed of the risks. The authors of the study acknowledge that some patients do lie, but feel this explanation does not account for flawed recall of the informed consent discussion. They concluded instead that when patients come to ophthalmologists with a visual



problem, they have already made a decision to have surgery in order to solve the problem and improve their vision. When confronted with what they perceive as negative objections (i.e., an accounting of associated risks), patients experience stress. Since they need to feel comfortable with their decision and minimize the stress, patients hear (and remember) what enhances a positive attitude and devalue (and forget) objections. In other words, patients “believe in and hope for the best.” To counteract this cognitive dissonance and help patients take in more accurate information about the risks of treatment, patients should be given information about the procedure earlier than the day before surgery.⁷

Why Don't Patients Hear?

JE Pauling, an expert from a non-medical field who has studied how to communicate risks to the public, feels the problems lie not so much in how patients process information as in the way it is communicated to them.⁹ In other professions such as aviation and nuclear energy, there is great concern about the consequences of misunderstanding. To decrease its likelihood, only a few well-trained individuals are authorized to speak to the public. They always begin their message by addressing the potential emotional impact of the message before going on to provide information in the form of visual aids.

In the medical field, almost all clinicians are called upon to communicate risk. They receive little to no training, minimize their own and the patient's emotions, and offer data with few visual aids. Poor process and training are only part of the problem, Pauling argues. Physicians want to build trust with their patients and know that it depends in part upon showing the patient that one is a good doctor. They assume that their patients know they

DESCRIPTION	FREQUENCY	ODDS
Very high	10-100%	1 in 1 to 1 in 10
High	1-10%	1 in 10 to 1 in 100
Moderate	0.1-1%	1 in 100 to 1 in 1000
Low	0.1-0.01%	1 in 1000 to 1 in 10,000
Very low	0.01-0.001%	1 in 10,000 to 1 in 100,000
Minimal	0.001-0.0001%	1 in 100,000 to 1 in 1 million
~ Zero	< 0.0001%	1 in 1 million to 1 in 1 billion

care (“I went into medicine to help people”) and focus their efforts on demonstrating their competence, calling upon science and probability to calculate comparative risks. They are quite comfortable both with accepting a certain level of risk as inherent in treatment and with the uncertain, ever-changing nature of knowledge. Patients, on the other hand, assume that physicians are competent (“she went to medical school”) and watch anxiously for signs that their physician cares about them. Disregarding the data, they are only interested in hearing if the proposed procedure is or isn't safe for them and knowing the personal consequences of treatment. Moreover, patients consider any discussion of uncertainty as evidence not of competence but rather of the physician's lack of knowledge (“he doesn't know the answer”).

Pauling illustrates his points and begins to give some practical advice with the following example. Imagine you are an obstetrician and are trying to help a 39-year-old woman understand her risk of having a fetus with Down's syndrome. You know that it is 1.2% or 1 in 83. You provide these figures and reassure the woman that her risk is “quite low.” As Table 2 shows, however, a patient's perception of quite low is different, as anything higher than 1% is actually considered a high risk. Only when the likelihood falls in the 1 in 1000

to 1 in 10,000 range is it considered by patients to be a low risk.

In addition to using the same risk calculus, there are other steps physicians can take. First, use a common denominator to place the particular patient's risk in a continuum (e.g., for a 35-year-old woman, the risk of having a child with Down's syndrome is <3/1,000, and for a 40-year-old woman, it is <9/1,000). Second, to improve the likelihood of being understood, the physician can translate this information into a visual aid by using a graph available online at www.riskcomm.com. A 35-year-old woman would see a chart with stick figures for 1000 people. Three of those would be darkened to represent the number of women who will have a Down's infant. The woman would also note that the vast majority—997/1000 women in her age group—are likely to have a child without Down's syndrome. Providing both a positive and negative perspective and context enhances the message. Finally, relate the risk to one the patient knows and understands (e.g., people have a 1 in 10,000 risk of being struck by lightning or of dying from an accident in their own home).

Please go to the **Risk Management Recommendations** section of www.omic.com for an extended version of this article, including detailed suggestions for the consent process and footnote references.