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Staying Out of Trouble: Strategies based on recent OMIC oculofacial plastic surgery claims

ROBERT G FANTE, MD, FACS, OMIC Board of Directors

Every oculofacial plastic procedure carries the risk of failing to improve a patient's condition or appearance. Hence, every ophthalmologist must learn to manage disappointing outcomes and help patients move forward with acceptance or additional treatment. Breakdown in the physician-patient relationship can contribute to the likelihood of medical malpractice claims against the physician. This article discusses common problems that occur in oculofacial plastic procedures and suggests strategies to avoid malpractice claims.

Introduction

In the United States, there are approximately 1,600 ophthalmologists who self-identify as specialists in oculofacial plastic surgery according to the American Academy of Ophthalmology (AAO). Among these are the over 800 members of the American Society of Ophthalmic Plastic and Reconstructive Surgery (ASOPRS). In addition, there are numerous surgeons from related disciplines such as otolaryngology, plastic surgery, and dermatology who also frequently perform oculofacial plastic surgical procedures.

OMIC provides medical professional liability (malpractice) insurance for the largest segment of US ophthalmologists, with approximately 6,450 member physicians as of 2024. Using OMIC's database of all closed oculofacial claims, lessons can be learned regarding the issues that arise in this subspecialty.

Approximately 20-25% of all claims will end in an indemnity payment to the claimant, typically via a settlement or, more rarely, a jury verdict award. Indemnity payments for oculofacial plastic surgery averaged $215,000 versus an average of $280,000 for all specialties of ophthalmology according to a study analyzing the closed claims from 2006-2015 of 20 US medical liability insurance carriers.[1] It has been estimated that by age 65, 99% of physicians in high risk specialties and 75% of those in low risk specialties, including ophthalmology, can expect to have had a medical professional liability claim against them, and 71% and 19%, respectively, will have made an indemnity payment.[2]

Laws governing the practice of medicine vary by state, and physicians should become familiar with the laws where they practice. While the definition of the standard of care is state dependent, the core concept is universal. The standard of care is generally defined as the level of skill, knowledge, and care that a reasonably competent and prudent physician would use in the same or similar circumstances. Some states apply a national standard, while others apply a local or regional standard. The standard of care is determined on a case-by-case basis by the medical experts who testify about the care.

While practicing medicine within the standard of care is not a guarantee against dissatisfied patients

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MESSAGE FROM THE CHAIR

ROBERT GOLD, MD, OMIC Board of Directors

It is truly my honor and privilege to enter my third and final year as the Chair of the Board of OMIC. The first 2 years have certainly been eventful with the retirement of our long time CEO Tim Padovese in 2023 and transitioning to our new CEO, Bill Fleming in 2024. Bill has brought over 30 years' experience in the medical professional liability space to OMIC and brought fresh ideas to the table while continuing the OMIC culture of support to an outstanding staff. The unique style of the physicians on our board and committees brings ophthalmic expertise to your company that is unlike the leadership of any of our multispecialty competitors. Our MDs represent all ophthalmic subspecialties and have the expertise to analyze claims and underwriting issues from a medical perspective. As I listen to the discussions between physicians and insurance experts, I can assure you that all are represented in a first-class way.

Our number of insureds has reached over 6,450 and we have a healthy surplus to be able to represent our insureds with the best attorneys and physicians so that any claim can be handled with expertise and professionalism. Your premiums will continue to be very competitive in our space and we hope

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EYE ON OMIC

OMIC capitalization strongest level recorded by rating agency

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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 in 2024 showed policyholder growth that exceeded our year-end projections by a wide margin, surpassing 6,450 insured ophthalmologists.

The A.M. Best Company re-affirms OMIC's financial strength rating

OMIC's strong balance sheet was referenced by the A.M. Best Company when they once again reaffirmed our "A" Excellent financial strength rating in 2025. The rating reflects that OMIC has the "strongest level of risk-adjusted capitalization recorded by A.M. Best, as measured by Best's Capital Adequacy Ratio (BCAR)." A.M. Best recognized our long-term history of organic surplus growth despite substantial policyholder dividends that have significantly exceeded those of our industry peers for many years, and which are a function of our business model and commitment to our members.

One area of concern for the entire insurance industry is social inflation in the US. As defined by A.M. Best, this is the rise in current or future claims caused by higher court awards and legislated increases in claims payments driven by societal behavior, including changes in demographics, litigation financing, a perceived decay in the public trust of corporations, and changes in tort reform. Therefore, we strongly encourage members to contact their representatives to express the need for, and maintenance of, tort reform that limits severe malpractice settlements. The continued availability of ophthalmic care depends on stability in the insurance market, which in turn depends on the prevention of increased settlement payments and "runaway" judgments.

Essential risk management resources for your practice

Providing a positive patient experience and delivering high-quality care requires effective risk management. OMIC offers a range of risk management resources to help you navigate common challenges and mitigate liability risks.

Our team of risk managers log common questions received through OMIC's confidential risk management hotline and from them develop resources to aid insureds and their staff. Trending topics include:

- Noncompliant Patients
- Termination of Care
- Navigating Challenging Patients
- Refunds
- Patient Notification & Continuity of Care When Leaving a Practice
- Anesthesia Liability
- Consent Forms & Re-Consenting Requirements
- Follow-Up Policy for Tests & Closing the Loop on Referrals
- Informed Consent Process
- Pre-Op Assessments
- Responding to Unanticipated Outcomes or Complications
- Proper Documentation Practices
- Telephone Screening & After-Hours Calls
- Comanagement with Optometrists Guidance
- Disclosure of Adverse Events
- Communication Requiring Interpreters
- Ambulatory Surgery Centers Guidance
- Time-Out Process for Procedures

For resources that explore these topics and provide protocols and guidelines for improving patient care and reducing exposures to litigation, visit www.omic.com.

MESSAGE FROM THE CHAIR

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to continue to pay you back for your investment with policyholder dividends in the future. Our partnership with the AAO continues to thrive, having a positive relationship with their board of directors as well as between our CEOs. This is essential for the future of both organizations.

If you haven't already, please check out the enhancements that we have done to OMIC's website. It is a great upgrade and we welcome any comments about our new look.

Finally, please attend your subspecialty or state society meetings and maintain membership. OMIC provides premium discounts to society partners' members to help them defray the cost of their dues, in order to support the specialty we all love. Attend an OMIC seminar if offered to get an additional discount on your premium. And when you start to prepare your AAO Annual Meeting schedule in October, make time to attend the Spivey Lecture in honor of one of the finest members of our specialty.

POLICY ISSUES

Volunteer work

KIMBERLY WYNKOOP, VP, OMIC General Counsel

Many ophthalmologists share their skills and knowledge without compensation to better the lives of others. They may engage in a wide range of volunteer work, including medical mission trips in low-resource areas where access to eye care is limited. Ophthalmologists might perform cataract surgeries, offer free eye exams, distribute prescription glasses, or treat common conditions like glaucoma. They might offer similar services closer to home, by volunteering in free or low-cost clinics, schools, or homeless shelters. Sometimes, ophthalmologists render unpaid emergency eye care services in areas affected by natural disasters, both near and far.

Organizations like Orbis International, SEE (Surgical Eye Expeditions) International, and Lions Clubs International often coordinate these efforts, providing platforms for ophthalmologists to volunteer their time and expertise. These organizations may provide medical professional liability insurance for their medical volunteers. If they do, it would typically cover claims arising from services provided during the mission or at the volunteer site.

State Good Samaritan laws provide liability protection for healthcare professionals who volunteer in emergency situations. OMIC's policy also protects you for Good Samaritan activities. The policy defines a "Good Samaritan" as a person who, in good faith, renders emergency medical care to an injured person at the scene of an accident or emergency without expecting to receive compensation from the injured person. While OMIC's policy covers ophthalmologists only for treatment "within the ordinary and customary scope of practice of ophthalmologists," OMIC considers non-ophthalmic treatment provided as a Good Samaritan to be within the ordinary scope of ophthalmologists. Because state Good Samaritan laws vary, OMIC strongly recommends that all insureds treating patients who have been injured in an emergency or disaster maintain at least basic documentation of any treatment rendered, including identifying information of the patient, a short narrative summary of the diagnosed condition, and specific medical care delivered. If a patient is unconscious or unable to communicate, Good Samaritan laws typically recognize that patients would want life-saving (or vision-saving) treatment, which allows a Good Samaritan to provide care without explicit consent.

Some states also have charitable immunity laws that offer liability protections for providers who volunteer at free clinics. OMIC recognizes and supports our insureds' volunteer activities to support underserved communities. Therefore, OMIC also extends coverage to insureds who provide unpaid services that include both ophthalmic and basic non-ophthalmic services like general health check-ups. OMIC's policy covers services rendered anywhere – inside or outside of the United States – as long as the claim is filed in one of the 50 states or the District of Columbia. Note, however, that claims are more likely to be filed in the jurisdiction where the services were provided or where the patient resides. Therefore, if you routinely provide services outside the US, we encourage you to obtain coverage from a carrier authorized to operate in the relevant country or territory. Please contact your Underwriting representative if you plan to provide services outside of the US as coverage is subject to Underwriting approval.

You may be wondering how volunteer activities affect your insurance coverage after retirement. OMIC provides a free extended reporting period ("tail") endorsement to insureds upon retirement. Under a tail, you are covered for incidents that occurred between your retroactive date and the end of your final policy period that are reported after your policy terminates. OMIC's policy defines retirement as the total and permanent discontinuance of the clinical practice of medicine for compensation. Therefore, you are still eligible for a free tail upon retirement even if you continue to perform volunteer, i.e., unpaid, services.

Activities you perform after your policy termination date are not covered under your tail. Therefore, if you are retired and providing volunteer services, you will want to make sure that the organization you are working with is providing medical malpractice insurance to you, or that you have a stand-alone policy for these activities. OMIC offers a volunteer services-only policy for such activities. Follow these recommendations and Contact your Underwriter for more details.

- *If you are volunteering through an organization, check to see if they provide MPL coverage for volunteers, what the policy covers (including any exclusions that may apply), and what the limits of liability are.*
- *Check with OMIC to understand what volunteer work is and is not covered under the policy.*
- *Comply with the coverage requirements of all applicable insurers. Make sure services you are providing are within the purview of coverage.*
- *If providing care in a different state or territory than where you are licensed, comply with the licensure provisions and requirements of your state of practice as well as those in the location where you will provide services.*
- *Whenever possible, conduct informed consent discussions for any procedures.*
- *Create a chart for each patient and arrange proper follow-up care.*

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and potential malpractice claims, practicing below the standard of care is associated with a higher rate of successful claims against physicians. In a recent OMIC study of oculofacial plastic surgery claims that experts deemed below the standard of care, an indemnity settlement was made in 84% of claims. Conversely, for cases with alleged patient harm due to complications that are well-recognized in the medical literature and treatment met the standard of care, indemnity settlements were made in only 10% of claims.[3] Circumspect judgment, timely referrals to colleagues for assistance when needed, and continuing education are useful strategies to meet the standard of care.

Lawsuits for medical malpractice are civil, not criminal, legal actions and are thus governed by tort law. Patients must show that the physician acted negligently in rendering care and that the negligence resulted in injury. Typically, the following four legal elements must be established: the physician had a professional duty owed to the patient; the physician breached that duty; an injury was caused by the breach; and the breach resulted in economic damages (lost wages, cost of health care), non-economic damages ("pain and suffering"), or both.

Although trends and experience will not necessarily predict the future medicolegal climate, this article will summarize some of the most useful lessons learned from recent claims.

Particular problem areas in the practice of oculofacial surgery

Cosmetic dissatisfaction with the results of blepharoplasty (or other oculofacial plastic surgery) is the single most common reason for a claim against the surgeon. Yet such claims rarely result in a financial settlement or indemnity payment.[3] When loss of function occurs from surgery, however, and there is a breach of the standard of care, settlements are often paid.

Blepharoplasty and ptosis repair

Blepharoplasty is the surgery most frequently associated with a malpractice claim for this subspecialty. This is not surprising since blepharoplasty is the single most common oculofacial plastic procedure. Large settlements ranging from $300,000 to $1,300,000 have been paid by OMIC for permanent visual loss due to retrobulbar hemorrhage after blepharoplasty, most commonly from failure of the surgeon to promptly and adequately address the situation. Smaller settlements of $150,000 to $430,000 have been paid for other complications, including lagophthalmos, corneal damage, and worsened dry eye. Similar settlements are associated with ptosis repair. Practice patterns that avoid or aggressively manage these problems are recommended to prevent malpractice settlements.

Brow lifting

Most other types of oculofacial plastic surgery care are less commonly associated with claims, although claims related to orbital, lacrimal, trauma, and periocular reconstruction have been reported. Brow lifting is rarely associated with successful claims. Only one has resulted in indemnity (under $30,000) in the past twenty years for OMIC. The majority of brow lift claims have been based on cosmetic dissatisfaction and have not resulted in an indemnity payment.

Invasive skin treatments

Laser and chemical peel skin treatments for actinic damage or facial aging such as rhytids and dyschromias are common oculofacial plastic procedures performed in many practices, often by the physician and sometimes by ancillary staff. In OMIC's experience, skin scarring with periocular deformity (e.g., ectropion) or perioral and cheek deformities have led to multiple settlements with indemnity payments ranging from $125,000 to $900,000. Conservative planning, careful training and supervision of staff, and close post-procedure management are reasonable strategies to prevent scarring and liability claims.

Fillers and autologous fat

While there have been no claims related to autologous fat grafting or hyaluronic acid fillers in the recent OMIC database, there have been several claims associated with adverse outcomes from Radiesse® hydroxylapatite facial filler in the upper face.[3] Of these, two claims alleged unsatisfactory cosmetic appearance, while the third alleged infection. It is recommended that careful informed consent be obtained regarding the potential complications with Radiesse® (and fat) including the relative difficulty in removing either material in the event of a problem.

Goals for the oculofacial surgeon

The goal of every oculofacial surgeon should be to meet the needs of the patient. To do this, the surgeon must establish the correct diagnosis, know when to say no to surgery, communicate effectively with the patient, obtain proper informed consent with the risks, benefits, and alternatives to the treatment explained, execute the surgical plan, follow-up with the patient, and manage complications.

Establishing the correct diagnosis

Although allegations of failure to diagnose or treat a serious medical problem is not common in oculofacial plastic surgery claims, OMIC has had several large settlements result from such claims. For example, a claim for alleged failure to diagnose squamous cell carcinoma that resulted in enucleation and maxillectomy led to a $975,000 indemnity payment. A claim for alleged failure to diagnose glaucoma in a patient who was left on topical loteprednol for months after blepharoplasty resulted in a $400,000 indemnity payment. A physician's clinical vigilance during routine patient care is the best defense to avoid similar claims and indemnities. For unusual or difficult situations, it may be helpful to arrange re-evaluation, or referral for a second opinion.

Knowing when to say no to treatment

There is a complex interplay between the patient's anatomy, pathology, and

coexistent medical, psychological, and social factors that may affect surgical decision-making and outcome. Not every patient is a good candidate for treatment, nor is the evident pathology always amenable to successful treatment. Consider saying "No, I am unable to help you" to new or existing patients in any of the following circumstances:

1. Multiple prior surgeries for the same (or similar) problems have been unsuccessful. Exercise caution if no records are available, or if the records show that the previous failed plans are similar to the ones you propose.
2. Substantial anger at a previous surgeon is detected, or the patient describes social isolation as a result of previous treatment. Listen and avoid patients who share phrases such as "My life is ruined," or "I can't go out."
3. A patient treats your staff with disrespect, violence, or consistent rudeness.
4. A patient pushes you to cut corners or create a new procedure just for him or her.
5. Magical thinking is detected, for example, "My husband will love me again," or "This surgery will help me get a promotion at work."
6. Your trusted staff tells you the patient seems erratic or unstable, or is extraordinarily demanding.

Effective communication

Controlling for the difference in the number of male and female insured ophthalmologists in the US, a study published in 2014 reported that male ophthalmologists had 1.54 times more claims against them than females.[4] Within oculofacial plastic surgery, male physicians had 1.25 times more claims than females. While the etiologies for this disparity are complex, differences in gender communication styles have been studied and may play an important role. Female physicians generally engage in more "active partnership, positive and emotionally focused talk, and psychosocial counseling."[4] Although the correlation between the quality of patient-doctor relationships and malpractice claims is also complex, both male and female physicians can work to communicate interest, empathy, and availability for all patients. Doing so has been correlated with improved patient trust, satisfaction, and forgiveness, as well as reduced liability.[5] In cases of potential medical error, communicating an honest explanation is important. Understanding the patient's perspective about their concerns and medical issues is critical. Taking time to listen to stories and feelings about "Mom's skin cancer" or "Dad's eye complication" may be helpful in establishing trust to improve the patient-doctor relationship and assist in decision-making.

Do the right procedure for the right patient

Many textbooks and fellowships concentrate on the details of correctly choosing which oculofacial procedure(s) is most likely to improve your patient's condition. It is incumbent upon the surgeon to explain the nature of the pathology, details of the proposed treatment, and expected outcome at a level of complexity and language the patient can understand.

Informed consent

Informed consent is an oral agreement reached after a conversation between the treating physician and the patient about the condition, proposed procedure, and its risks, benefits, and alternatives. The record of that consent must be documented in the medical record. The discussion and documentation must be detailed enough to identify the risks and potential complications that are commonly encountered, or which are rare but severe enough that a reasonable person would want to know they are possible (such as blindness). The process must have allowed the patient an opportunity to ask questions and confirm understanding of the issues involved. Inadequate evidence of informed consent is a major problem in a malpractice claim, even if the standard of care was otherwise met. The likelihood of an indemnity payment is far higher if informed consent cannot be established. In fact, recent OMIC experience shows that the majority of such claims resulted in an indemnity payment. On the other hand, complications that occur during or after surgery that were clearly discussed preoperatively are typically less likely to be seen by the patient as a mistake or to result in a claim. Insureds can download plain language consent forms in English and Spanish for common oculofacial plastic surgery procedures at www.omic.com.

For cosmetic patients, a separate Cosmetic Financial Consent can help to alleviate conflicts regarding payment for "touch-ups" and can reinforce the idea that a guarantee of 100% satisfaction cannot be made. Always strive to clarify both the surgeon's and the patient's expectations of treatment.

Surgical plan and execution

A written surgical plan should be documented at a preoperative visit, and the informed consent document should match the planned procedure. If conditions are found in surgery that alter the plan so that it is executed differently, the reasons should be explained clearly in the operative report or noted elsewhere in the patient's medical record on the day of surgery. Any deviation from the surgical plan should also be explained carefully to the patient or family on the day of surgery after the patient is no longer under the influence of anesthetics.

Patient follow-up

Follow-up should be scheduled and documented based on the underlying condition, the surgical procedures performed, coexisting medical conditions, and any unintended complications seen. Referral to other specialists should be sought for any unstable or new condition. In addition, if treatment includes a planned hiatus from anti-coagulant therapy, it is imperative that the surgeon ensure the patient follows up with the treating physician to resume anti-coagulation.

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CLOSED CLAIM STUDY

Delay in treatment results in light perception vision in one eye

RYAN M. BUCSI, OMIC Claims Vice President

Allegation

Delay in treatment of retrobulbar hemorrhage post blepharoplasty resulting in light perception vision in one eye.

Disposition

Settlement of $700,000.

The patient presented to an OMIC insured and during the initial examination a history of hypothyroidism, high blood pressure, arthritis, and sagging eyelids related to thyroid disease were documented. Approximately 2 months later, the patient returned to the insured for a cosmetic bilateral upper eyelid blepharoplasty. There were no complications, and the patient returned home, which was a 4-hour drive.

The following day, the patient noticed bleeding and vision loss in the right eye. The patient contacted the OMIC insured's office around 9 am, was asked to send a photo of the eye, and was asked to come into the office on this day. The patient arrived in the office around 2 pm. Upon examination, the insured diagnosed a retrobulbar hemorrhage in the right eye. The vision was light perception. The insured opened the right blepharoplasty wound, removed sutures and a clot, and performed a lateral canthotomy and cantholysis. The patient was given antibiotics and prednisone. The next day, the patient returned to the insured with light perception vision in the right eye. The pupils were normal, with no afferent pupillary defect. Two days later, the patient returned to the insured with light perception vision in the right eye and briskly reactive pupils with a trace relative afferent pupillary defect. The insured gave the patient Besivance samples and asked the patient to follow up with a retina specialist. Approximately one week later, the insured examined that patient for the last time. The visual acuity remained light perception in the right eye.

One month later, the patient informed the insured that the patient was being followed by a retina specialist closer to home. The patient's visual acuity in the right eye never improved from light perception.

Analysis

Plaintiff experts' main criticism was how the complication was managed in the immediate post-operative course. Specifically, plaintiff experts opined that the OMIC insured should have instructed the patient to head directly to a local emergency room or a local ophthalmologist versus having the patient drive 4 hours to the office. They testified that having the patient drive 4 hours delayed treatment of the retrobulbar hemorrhage that led to light perception vision in the right eye. Plaintiff experts argued that, had the OMIC insured advised the patient to seek emergent care locally, the vision in the right eye could have been saved.

While experts for the defense opined that having the patient drive 4 hours to the office was indeed a valid criticism, they did not agree with plaintiff experts that, had the patient been seen sooner, the vision in the right eye would have been saved. The defense experts stated that a retrobulbar hemorrhage damages the eye by causing a compartment syndrome in the eye socket, which causes the orbital pressure to rise to the point that the arterial blood supply to the retina, through the central retinal artery, is stopped or diminished. Once this happens, there is somewhere between 1.5 hours and 4 hours to treat the hemorrhage. After this period, the damage is done, and it is permanent. Therefore, it was likely too late to change the outcome by the time the patient reported the complication to the OMIC insured. However, the defense team believed that proving this point to a jury would have been challenging.

Takeaway

The patient's vision was 20/20 prior to the cosmetic lid surgery and the final visual acuity in the right eye was light perception, a significant vision loss. It is critical to treat a retrobulbar hemorrhage following lid surgery within 1.5 to 4 hours after such a complication. If the insured had advised the patient to seek care locally, we might have been able to develop more of a causation argument. We would have known definitively whether it was indeed too late to treat the complication when the patient first reported the complication around 9 am the morning after surgery. The insured's decision to have the patient come into the insured's office 4 hours away gave plaintiff experts a viable criticism that the delay in treatment affected the ultimate outcome.

Since our experts and defense counsel felt the case would likely not be successfully defended if tried in front of a jury on standard of care and causation, a settlement of $700,000 was negotiated.

Pearls to avoid lawsuits and conclusions from the lead article

The goal of all oculofacial plastic surgeons should be to have patients who are satisfied with their final outcome and each episode of care. Unfortunately, that goal does not always translate into every patient care experience and malpractice claims will sometimes occur. Oculofacial surgeons can learn strategies to reduce the risk of medical error for their patient and mitigate the risk of medical liability claims. OMIC Risk Management can provide confidential guidance to its insureds about responding to challenging patient situations. Follow these pearls to avoid claims and lawsuits:

1. Know when to say NO.

2. Make sure that every cosmetic patient completes a Cosmetic Financial Agreement before the first surgery that details the practice's policies and charges for revisions. Even if you choose to waive any charges, it is better that the patient knows the policies beforehand.

3. When surgery has been completed and problems arise:

i) When low risk and simple interventions are possible, it may be sensible to help the patient by taking action (e.g., injecting filler or revising a scar to subtly improve blepharoplasty results).

ii) Communicate your plan clearly and make them feel that you care (e.g., "here are our options," "if you were my child/spouse/parent, I would….")

iii) Avoid defensiveness or silence, which do not communicate the caring attitude that patients seek. Keep (or regain) their trust with eye contact, proximity, and listening intently.

iv) Show empathy and say you are sorry that things are working out this way; make them feel that you are their ally in the struggle for a good result (e.g., "I want to get you across the finish line.")

4. Make problem patients feel like VIPs by seeing them often until minor issues are resolved, while subtly adjusting their expectations toward realistic possibilities. At times, regular phone communication until the issue is resolved can be helpful.

5. Take professional quality preoperative photos and offer copies to the patient so that the positive effects of your treatment can be remembered readily.

6. If concerns about the outcome arise, discuss your concerns confidentially with the Risk Management Hotline.

Wise surgeons will tell you that they never regretted saying no to someone, but they may certainly have regretted saying yes.

Lead article references:

[1] Thompson AC, Parikh PD, Lad EM. Review of ophthalmology medical professional liability claims in the United States from 2006 through 2015. Ophthalmology 2018 Jan13. https:// doi: 10.1016/j.ophtha.2017.11.018

[2] Jena AB, Seabury, S, Lakdawalla, D, Chandra A. Malpractice risk according to physician specialty. N Engl J Med 2011 August 18; 365(7): 629-636.

[3] Fante RG, Bucsi R, Wynkoop K. Medical Professional Liability Claims: Experience in Oculofacial Plastic Surgery. Ophthalmology 2018:125(12)1996-1998.

https://doi.org/10.1016/j.ophtha.2018.08.016.

[4] Fountain TR. Ophthalmic malpractice and physician gender: a claims data analysis. Trans Am Ophthalmol Soc 2014;112:38-49.

[5] Hannawa AF. Explicitly implicit: examining the importance of physician non-verbal involvement during error disclosure. Swiss Med Weekly 2012;142:w13576.

[6] Lambert BL, Centomani NM, Smith KM, et al. The "seven pillars" response to patient safety incidents: effects on medical liability processes and outcomes. Health Serv Res 2016 Dec;51 Suppl 3:2491-2515.

[7] McDonald TB, Helmchen LA, Smith KM, et al. Responding to patient safety incidents: the "seven pillars". Qual Safe Health Care 2010;19:e11.

[8] Mazor KM, Reed GW, Yood RA, et al. Disclosure of medical errors: what factors influence how patients respond? J Gen Intern Med 2006; 21: 704-710.

[9] Ross NE, Newman WJ. The Role of Apology Laws in Medical Malpractice. J Am Acad Psych Law Online May 2021, JAAPL.200107-20. https://doi.org/10.29158/JAAPL.200107-20

Staying Out of Trouble

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At each post-treatment visit, the results should be observed and communicated to the patient with openness and honesty. Anticipate patient concerns. It may be appropriate to explain the natural course of wound healing and the patient's variance from average. Communicate complications if they arise. Clear instructions regarding home care and medications must always be provided. Finally, communicate your assessment of the final result in an open and honest way, while also listening to the patient's assessment.

Actively manage complications

If any complications occur during surgery, or if complications arise during the post-treatment course, it is best to candidly explain the situation and actively manage the problems. Patients usually appreciate the opportunity to directly contact the surgeon. It may be helpful to establish greater trust and alliance by providing a cell phone number or other direct contact information.

Revisit patient expectations frequently

Whether the post-treatment course is simple or complex, it is also valuable to re-visit patient expectations frequently. Reminding patients of their pre-treatment condition, often with the use of photos, can be very helpful to engender acceptance of minor post-treatment imperfections.

The Unhappy Patient: Cosmetic dissatisfaction and patient expectations

The single most common reason for claims against oculofacial surgeons is cosmetic dissatisfaction, but these claims are also the least likely to lead to an indemnity payment. Most surgeons have worked with patients who can be difficult to please, and even expertly-performed surgery will not always provide the intended outcome. As a consequence, most surgeons will have the occasional patient who is unhappy with his or her postoperative appearance despite having achieved the preoperative goals without complications. For these patients, there has been no breach of the standard of care, and, by definition, there are no functional problems. These cosmetically dissatisfied patients can be separated into two groups: (1) those who have one or more minor asymmetries or contour abnormalities that the surgeon can see and possibly correct, and (2) those who have an ideal of potential, future beauty that can be difficult for the surgeon to appreciate, is based on much earlier versions of themselves, or is impossible to achieve. The surgeon may choose to offer additional treatment to someone in the first group, while for those in the second group, additional treatment can be problematic. In both cases, there is no malpractice by declining to offer further treatment since there is neither duty nor harm. Open communication is critical in both situations.

In practical terms, this dual strategy – fixing small problems when possible and declining when appropriate – translates into fewer successful malpractice claims against oculofacial surgeons based solely on cosmetic dissatisfaction. The first group above can often be satisfied with a minor revision, while the second group will usually have little foundation for a claim. In the OMIC data, only 2.7% of such claims resulted in an indemnity payment and the payments were small, averaging $13,500.[3] Although the risk of indemnity claims appears minor, it should also be understood that cosmetic dissatisfaction is the single most common reason that claims have been filed against oculofacial surgeons. The nuisance factor for physicians is substantial, and can result in anxiety, insomnia, and negative social media. Fortunately, there are several strategies that can help reduce the likelihood of a claim and its attendant problems.

Refunds

For some unhappy patients, it may be sensible to consider offering or agreeing to a refund if that will satisfy them and there are no concerns about the quality of your care. Details matter here; an oral discussion with the patient (regardless of who initiated it) that leads to a refund is not reportable to state medical boards or the National Practitioner Data Bank (NPDB). However, a written demand for money (even if only a refund) generally falls under a reporting entity's definition of a claim. If a refund exceeds the amount the patient originally paid, it is more likely to be considered a reportable indemnity payment. Your claims representative can help you determine if reporting the payment is required. It is advisable that surgeons request a release of liability from the patient in exchange for a refund. A valid release of liability should be written by a qualified medical liability attorney in your state. Note, however, that asking for such a release may raise questions in the patient's (or family's) mind about possible medical error.

I'm Sorry Laws

In order to promote better communication in difficult situations, 39 states and the District of Columbia have laws that make an expression of sympathy and/or culpability by a physician to the patient or family inadmissible as evidence of negligence or an admission of liability. Apologizing for the more difficult path experienced by the patient with a suboptimal outcome or a complication may make the physician appear less arrogant, help to defuse anger, and prevent a lawsuit or claim. Saying "I'm sorry" also makes it easier to disclose information about an adverse event. Since all states consistently uphold the duty of physicians to be honest health advocates for the patient, disclosure is ethical and necessary. As several institutions have moved to early communication of errors with the patient and family, including full disclosure and apology when errors occur, dramatic reductions in claims, lawsuits, settlement, legal expenses, and total liability costs have been reported.[6, 7, 8, 9]

When confronted with a patient who has had an adverse event, physicians in large institutions or small private practices will generally find that empathetic care, full disclosure, and some expression of regret are helpful in defusing anger and avoiding claims. Among the resources that may be helpful when responding to difficult situations is an OMIC online guide: Responding to unanticipated outcomes. Knowing your state laws and what types of apologies are protected from use against you in litigation is important. When in doubt, contact your claims representative.

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