Satisfied patients don’t sue

ESCRS roundtable panellists outline tips to improve patient satisfaction – and reduce risk of lawsuits

If forewarned is forearmed, then knowing why patients sue could help ophthalmologists avoid malpractice lawsuits, according to leading ophthalmic surgeons.

At the XXIII Congress of the ESCR in Lisbon, a panel of surgeons from across Europe convened in a roundtable discussion to share their insights on what causes patients to sue their ophthalmologists and how practitioners can reduce the risk of winding up in court.

The participants, selected for their clinical and medical-legal experience, included:

- Matteo Piovella MD, who practices in Milan, Italy and serves as secretary of the Italian Society of Ophthalmology;
- Paul Rosen FRCS FRCOphth, who practices in Oxford, England and serves as president of the United Kingdom and Ireland Society of Cataract and Refractive Surgeons;
- Thomas Kohnen MD who practices in Frankfurt, Germany and serves as associate editor of the Journal of Cataract and Refractive Surgery; and
- Jean-Luc Seegmuller MD who serves as president of the National Syndicate of Ophthalmologists of France and is a former president of the Ophthalmology Section of the European Union of Medical Specialists.

Facilitating the discussion were Emanuel Rosen FRCS, who practices in Manchester, England and serves as editor of the Journal of Cataract and Refractive Surgery; and Paul McGinn, who is a malpractice defence lawyer in Dublin, Ireland and serves as an associate editor of EuroTimes.

Paul McGinn: Why do patients sue their ophthalmologists?

Emanuel Rosen: Patients sue their ophthalmologists for a whole host of reasons. First of all, they’ve got an outcome that doesn’t meet their expectations and they’ve usually not been properly counselled to anticipate an outcome that is not satisfactory. That’s one reason they may sue. The second is that they’ve taken an aversion to their ophthalmologist to his or her manner and his or her handling of the outcome situation. Also, if a patient complains a lot, then, in my experience the partner, wife, family, or friends encourage the patient to have a go at the ophthalmologist because they see money at the end of the line. It depends on the occupation of the patients, how functional they are, and whether you can provide them with temporary functional correction until you can finally correct their situation. Of course, it also depends on whether you’ve actually committed an error of omission or forgotten to do something you should have done. So the watchword is to be very careful in what you do and double-check and triple-check when you are doing laser surgery to try and avoid these sorts of conflicts.

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Jean-Luc Seegmuller: Patients sue when they are not satisfied by their results, but you must distinguish between cataract surgery and refractive surgery. These are two completely different situations for us, and what we have realised in the last ten years is that the situation and the reaction must be strongly different. In cataract surgery, one-third of claims are due to endophthalmitis. Our professional association has created a national endophthalmitis survey body to analyse studies with insurance companies and lawyers to obtain conclusions and practical recommendations. What is emerging from this is that in fact in almost all cases — when we exclude those really exceptional colleagues whose almost psychopathological irresponsibility unfortunately isn’t effectively stopped by the authorities – no medical negligence can be brought to the floor. Concerning refractive surgery, every year more cases are breaking out and the cost of every case is going up to €150,000 on average, 10 times higher in the last 10 years. Some patients sue their ophthalmologists several years after their operation, even when the initial result can be considered by the surgeon as satisfactory. Other sorts of losses that must be indemnified include professional harm caused to patients in the military, those who drive, work with computers and even those patients who don’t get the job they were hoping for. Even the loss of pleasure can command a high price.

Paul Rosen: I think you can divide the cases into two. There are those where there has obviously been gross negligence and those cases are clear-cut. The surgeon’s done something which is outside normal practice or is not “being done by a reasonable body of medical opinion” and they’ve got it wrong. Those cases are quite clear but I think those are the more unusual cases or less common cases. More commonly, it is about poor patient satisfaction and poor communication between the surgeon and the patient. They may have been promised everything and you have only delivered 90% of everything. Often it’s a case where multiple small errors build up big resentment between the patient and doctor, and that leads the patient to seek legal advice. I think the last thing I would mention is the influence of colleagues, where the patient goes for a second opinion and that again can start the ball rolling. They look at an eye and say “Who on earth did that to you?” which then starts the process in the patient’s mind. We have to be diplomatic.

Matteo Piovella: In Italy, we perform about 600,000 operations, 500,000 cataract and 100,000 refractive operations per year. We have 50 cases each year that reach a court, which means one case for every 1,200 surgeries. With the information from those cases, we are finding the weak points in how Italian ophthalmologists organise their clinics and treat patients. An increasing number of cases appear to be related to the time that the organisation and the staff dedicate to the patient and the short time that the surgeon may spend with the patient. I also agree with Paul Rosen that 50% of these cases were brought to court due to a different opinion — that was not really a standard of scientific information — from other colleagues that pushed the patient to believe he was a victim of malpractice.

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It seems to me that it is clear that the relationship and trust have been undermined by a lack of communication. It is also important to remember that the patient is never satisfied with the result, so it is not possible to give them the result they want. That’s why we must always communicate with the patient and explain the risks and benefits of the surgery.

Thomas Kohnen: In Germany, there is an annual survey regarding the reputation of jobs and professions. Every year, the physician gets the highest reputation, much higher than lawyers much higher than anybody else, so patients really regard their physicians as people who have good education, good ethics, and do their job very well. When it comes to refractive surgery, I would agree with Paul that lawsuits arise when expectations are not fulfilled or where there have been intraoperative complications. From what I see from the courts in Germany, the usual cases involve surgeons who perform refractive surgery on patients they do not have the appropriate indications for the surgery. Over the last 10 years, Michael Knorz, Thomas Neuhann, and I have developed refractive guidelines that contain limitations for LASIK, limitations for PRK, and limitations for refractive lens exchange and phakic IOLs. If they go outside these limitations then that’s their problem and then really the whole thing starts. So what we tell our patients is really look to our guidelines. We work on these every year, we try not to make them too strict and they have helped us tremendously to limit bad results in refractive surgery.
Emanuel Rosen: Which ophthalmic surgeons are most at risk of being sued? Is there a typical personality or type of practice that puts the ophthalmologist at risk? In other words if you have a conveyor belt system are you more likely to be sued or are you more likely to be sued if you have an abrasive personality, or a pompous and dictatorial type of personality?

Thomas Kohnen: There are, of course, several personalities in all of us practicing medicine. As I said before, I think that those ophthalmologists most at risk are those who practice outside the knowledge we have currently or who are using technology that is not approved. These, in my opinion, are the people who really get the most problems.

Jean-Luc Seegmuller: We have only to observe in France and probably in other countries to realise that some colleagues practise outside of acceptable guidelines. Some of them have more cases than those who practice within guidelines, and some of them have no cases at all. I think we should analyse the typical personality of those who practise outside of those guidelines and their attitudes so that we can devise ways to reduce the risk of being sued.

Emanuel Rosen: I’ve been keen for the ESCRS as an organisation to provide refractive surgery guidelines that would work on a pan European level. What authority would such guidelines have in court?

Paul McGinn: I think that a case in point are the new ESCRS endophthalmitis guidelines that were just issued at this meeting. I think those guidelines are a fantastic step in the right direction. I would add that for at least the last five years the standard for the practice of ophthalmology and many other surgical specialties has become international. If there is any case of negligence, the body of opinion that a surgeon will be compared against is not necessarily the national one but the international one. Smaller countries such as Ireland have always been faced with that because if there is a lawsuit against an ophthalmologist, 100% of the time the expert comes from outside the jurisdiction.

Emanuel Rosen: Are you saying that it would be a defence to argue that even though you went outside, say the Italian national guidelines in a particular area like the management of endophthalmitis but you accorded with the European one, that you would still have a good defence?

Paul McGinn: The general law in most counties that I know of is that even if you choose to practice outside of any guidelines, if you can provide a good and acceptable reason for why, in this particular case, you practised outside the guidelines then you are not negligent.

Emanuel Rosen: I’d like the members of the panel to make a list of three conditions that are the most commonly made mistakes in ophthalmic surgery that they think lead to a lawsuit.

Jean-Luc Seegmuller: In France the situation is not disastrous. During 2003 fewer than 300 ophthalmologists – only about 5% of French ophthalmologists – have notified the insurance company about a possible claim. About one-quarter of those notifications were about only slight harm, such as mistakes in the prescription of glasses. About half of the notifications had to do with operations. Of these 150 notifications, 94 followed cataract surgery and 42 followed refractive surgery. Within cataract surgery, we had 32 cases involving endophthalmitis and 18 cases involving posterior capsular rupture.

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Emanuel Rosen: Should ophthalmic surgeons admit their mistakes to patients? Is honesty the best policy or are you making a rod for your own back?

Thomas Kohnen: I think there are three major points for me. Number one is bad preoperative examination, inadequate explanation to the patient, and poor performance of surgery. That’s number one. Number two would be bad management of complications, postoperative management, including the failure to talk to the patient and take the right steps. That brings us to the third point and that is not-good-enough self-judgment of the surgeon. That includes, of course, knowledge of the subject and education in this particular matter. These would be, in my opinion, the three most common mistakes made in ophthalmic surgery and I think you can apply this to cataract and refractive surgery.

Paul McGinn: If I could talk about the non-clinical mistakes, I think communication is always the biggest error. Also poor record-keeping is a major problem because, for the most part, cases cannot be defended when there is no evidence to present to a court. While the surgeon may be able to give evidence at some point of what his account was, you must always remember that judges generally will accept the evidence of the patient probably a little bit more than they will that of the doctor. This not because they don’t trust the doctor but because the doctor has probably performed hundreds, if not thousands of procedures, since the very one about which he is being sued. The patient, however, has focused on that event since it occurred.

Emanuel Rosen: In cataract surgery I think the main issues are biomeyoty errors and then poor communication with the patient by the doctor. So it doesn’t involve the same issues that the patient has in laser refractive surgery. In refractive surgery people have been chasing correcting a refractive error so the patient may have had multiple procedures, for example, flap lifts which have then resulted in a poor outcome. I think there also is a third group of patients, as in laser refractive surgery, in whom there are just multiple small so-called errors. They’re not major errors but they build up and are cumulative and that leads to dissatisfaction. There are also cases where there are, in fact, no errors at all, it’s just the patient trying to make some money.

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Paul McGinn: I think that studies would indicate that even in such a litigious country as the United States honesty is the best policy. The Veterans Health Administration – which is the largest health system in the United States – introduced the system whereby the patients and families were brought in – and even told to bring in lawyers if they wanted – as soon as a mistake was made. The patients were offered a settlement at that time by the hospital administrator. That whole system seems to have saved money over the old system in which there always was the fighting over liability, so I do think honesty is the best policy although it would put me out of a job.

Matteo Piovella: In Italy, we have found that three colleagues of ours have collected more than 50 legal court problems. This is a habit. This is a mentality. We need to isolate these colleagues and to publicise why they are wrong because this is a problem for everybody. Also I think we have to deal with the expectations of patients. For instance, I think their mentality is unbelievable. There was even an article in a popular newspaper in Italy that talked about giving pills to patients to treat their presbyopia. We can’t do anything about that, but I think one solution is to create better articles to make our patients more informed about the reality.

Emanuel Rosen: But that’s a complication. Supposing you make a genuine mistake, do the wrong operation, put in the wrong implant power because you’ve been given it. Do you admit the mistake and thereby admit liability. That’s the question really.