THE DIGEST
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An updated study of cataract surgery claims

LINDA HARRISON, PHD, VP, OMIC Risk Management

Premium IOLs are often described in the lay press as providing vision that is closest to one's natural sight, allowing patients to see both near and far without glasses. However, numerous factors, such as accuracy of preoperative measurements, ocular anatomy, and individual adaptation to IOLs can lead to surgical outcomes that do not meet patients' preoperative expectations. We performed qualitative analyses of medical records, patient complaints, and legal discovery to understand what motivated patients to file a claim after receiving premium IOLs or premium cataract-related services, such as use of the femtosecond laser or limbal relaxing incisions (LRI).

The number of cataract claims reported to OMIC remained relatively steady until an upward trend commenced in 2016, culminating in a peak of 97 new claims reported in 2019. The decrease to 75 new claims reported in 2020 is most likely attributable to surgeries that were postponed due to the pandemic.

TABLE 1. NUMBER OF CATARACT CLAIMS (2016-2020)

ALL cataract claims	299
Litigated claims (lawsuits)	136 (85)
Non-litigated claims	163
# indemnity payments	49
This study: claims involving ONLY premium IOLs and premium services	99
Litigated claims (lawsuits)	32 (19)
Non-litigated claims	67
# indemnity payments (litigated)	13 (9)
# cases	80

The Current Study

Between 2016 and 2020, 299 cataract claims were reported to OMIC; 99 claims (resulting from 80 cases) involved the use of a premium IOL or cataract service. Of these 99 claims, 32 were litigated (brought to court) by 19 patients. The number of claims is greater than the number of lawsuits because some patients named more than one insured physician as a defendant, and sometimes named an insured's practice. Nine of 19 lawsuits and four of the 67 non-litigated claims resulted in indemnity payments.

Costs of Defending Claims

Since 1987, cataract procedures have generated the largest number of claims across ophthalmic subspecialties. These claims are not only high in frequency, but are also expensive to defend. Cataract claims involving premium IOLs and services generated $964,000 in expenses and $3.42M in indemnity. While only 13% of cases closed with an indemnity payment, two-thirds of all cases (66) closed with an expense payment. The mean indemnity per claim was $263,077.

Reasons patients filed claims

We were unable to evaluate two of the 80 cases due to lack of information. Qualitative analysis of the remaining 78 cases revealed five categories that appeared to be the primary motivating factor for the case (in ascending order of frequency): postoperative need for glasses, a "wrong" event, billing issues, postoperative visual

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MESSAGE FROM THE CHAIR

DANIEL BRICELAND, MD, OMIC Board of Directors

The term "inflection point" is having its moment in 2021. The origins are from mathematics, meaning the point on a curve where it bends and changes direction. In physics, it's the turn of the wheel, when one's path is altered forever. And in business, it signifies the event that leads to a shift in how we move forward as an organization.

Clearly the pandemic has transformed our culture in ways that will almost certainly be permanent. The U.S. workforce is morphing through fits and starts to emerge anew as a scattershot army of people huddled in extra bedrooms or converted garages contemplate their new reality. One thing is certain, we are on a new and different journey that could be at once intimidating but also in many ways exciting.

I choose to focus on the new possibilities these changes may present for our future. I am amazed at how our employees, partners, and Board adjusted so quickly to handle significant change in the way we do business. It is not lost on me that after a year of severe challenge for so many, we've managed to rise and

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EYE ON OMIC

Enhanced CyberNet© risk management resources

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Cyber-related claims are on the rise. As you no doubt have seen in recent news reports, cyber hacking and online security breaches and ransom demands have increased dramatically during the past year.

OMIC includes cyber coverage up to $100,000 per insured in your standard policy. We now also offer CyberNET®, the most advanced cyber risk management solution, free and exclusively for policyholders. Visit OMIC.com/partners/cyber-liability-update/. The password for the cyber risk management library is omic2021.

To purchase additional coverage to supplement the $100K benefit included in your OMIC policy, contact Dana Pollard Carulli at 877-808-6277 or DPOLLARD@tmhcc.com.

Policyholder dividend declared

We are pleased to announce that the Board of Directors approved a 5% dividend for 2021, to be issued as a credit on your 2022 renewal policy. OMIC has issued nearly $100 Million in dividends to date. Additionally, OMIC will keep premium rates stable in all states for 2022.

MESSAGE FROM THE CHAIR

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persevere. We are more lean and nimble, battle-tested, and productive. OMIC had one of its best years in 2020.

Our staff quickly modified systems and procedures to accommodate remote servicing of our members. They did not skip a beat. I know of no major disruptions in our operations during the past year. OMIC implemented an industry-leading COVID relief initiative where insureds received significant financial assistance through various actions that involved extensive preparation and implementation by our finance and underwriting teams. This was all completed before May 2020, just a few months into the pandemic.

In the midst of dramatic shifts for our company, OMIC grew our policy count at the fastest rate in more than a decade. Our expenses, despite advanced technology investments, were lowered significantly. The lines and curves shown on our financial graphs and charts point in decidedly positive directions for our future. What a testament to our resiliency as a company.

As many of you are aware, David W. Parke II, MD, recently announced that he will be stepping down at the end of the year after more than a decade as CEO of the American Academy of Ophthalmology. This news prompts me to reflect on Dr. Parke's impressive tenure as leader of the Academy, including his crowning achievement, the IRIS Registry, and on the incredible impact Dr. Parke has had on OMIC since he joined our leadership team in 1999.

Already a seasoned financial steward for the Dean McGee Eye Institute, Dr. Parke possessed the vast operational knowledge we needed at one of the most pivotal times in our company's history. Two years after joining OMIC's Finance and Underwriting Committees, a sharp turn in the insurance market prompted the Board of Directors to make dramatic moves in order to strengthen our position and come to the rescue of many of our colleagues. The largest insurer in the U.S. at the time, The St. Paul Company, cited excessive losses when it abruptly left the market. Other carriers stopped writing new policies as the malpractice insurance industry veered toward unprofitability. OMIC was the only carrier writing coverage in some areas of the country and our premium rates remained far below competitors, who implemented sharp rate increases of double or triple what they had been the year before.

Dr. Parke was elevated to the Board and worked closely with another "giant" in OMIC's history, Dr. Stephen Kamenetzky, and other members of the Finance Committees to transform OMIC and the insurance market for ophthalmology. While some medical specialties experienced wild fluctuations in costs of doing business and uncertainty of maintaining practice, our profession survived the turbulent conditions in relative stability. Many of our peers were protected from severe threats to financial fortune by this bold leadership. Ophthalmologists could rely on OMIC and our company doubled in size in just three years. Soon after, Dr. Parke was elected Vice Chair of OMIC and later served as Chair of our Claims and Strategic Planning Committees.

There have been a handful of key leaders of OMIC that have shaped our company in such consequential ways. Dr. Parke is in that select group and on behalf of the Board we wish him the best as he transitions from OMIC to his next endeavors.

WEB SERVICES

New online billing and payment features

RICCI A RASCOE, OMIC Chief Financial Officer

OMIC is excited to announce that we will launch a new online billing and payment system October, 2021. Invoice Cloud offers more ways to view and pay your bill online, as well as the ability to pay by phone and by text. You will now be able to receive and view bills electronically and utilize multiple payment methods. When these new services are available online an electronic communication will be sent to all insureds with instructions for setting up your account profile.

Pay online

Although limited online account access and payments were previously available, now you will be able to choose to pay with electronic check in addition to a credit or debit card and other payment options. The new, easy-to-use payment portal features include an "at a glance" dashboard with increased options such as choosing a specific day for payments to process, requesting email reminders, and linking multiple accounts.

The new service will enable you to view and pay bills when convenient 24/7, schedule one-time or automatic payments, securely store payment information for later use, review up to 24 months of past bills (as they become available), and enroll in paperless billing.

Email notifications will be sent when the bill is ready to view, just before the due date, and when a scheduled payment is pending.

Set it and forget it

We strongly encourage you to use these new autopay features when they become available so that payments are confidently applied on the due date, avoiding the possibility of coverage lapses.

Pay by phone

The pay by phone option will also be available 24/7 and is a quick alternative for customers who may not be interested in going online. Insureds can simply call anytime, enter their account information, and follow the prompts to make a payment or get their latest account balance.

Pay by text

With pay by text, you can stay informed by receiving text notifications about your bill. You will have the option to respond via text message to make a payment using a default payment method. You can enroll in pay by text when making an online payment or within your online account.

Linking accounts

We understand that billing services are sometimes used to pay multiple invoices during the same online payment session. Now with the "shopping cart" feature you will be able to add multiple invoices to the payment method.

Options expanded

While online payments were available previously for most invoices, the new system will be able to apply payments for previously unavailable situations such as invoicing for new applicant policies and extended reporting period endorsements.

Enhanced security of data

OMIC is committed to a vigorous cyber security plan for all of our systems. We've worked closely with Invoice Cloud to apply advanced features to protect your financial information. Multiple layers of protection ensure that your data is safe from unauthorized access.

Services available soon

As mentioned above, the new payment portal will launch later this year. Watch for further instructions to set up your account and choose the autopay options most convenient for you. The portal will be accessed at **OMIC.com** by clicking on the "Pay My Bill" button at the top of the screen. You will also find the link under the Policyholder Services menu titled "Make My Payment".

Our commitment to going paperless

OMIC has been committed to lowering our impact on the environment by reducing physical copies of documents. Nearly twenty years ago we converted our internal filing systems to an electronic system. More recently, OMIC engaged the services of a state-of-the-art document production company to send certificates of insurance and other documents electronically, when possible. Finally, many of our flagship publications, including this ***Digest*** have been sent electronically and posted online to lessen our paper, ink, and postal delivery footprints.

Invoice Cloud is our latest venture to meet this commitment. Our goal is to provide completely paperless invoicing to all insureds. We hope you will help us to protect the environment for future generations. Sign up as soon as the new services launch in order to take advantage of the paperless invoice option.

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acuity, and complication at surgery or postoperatively. Over half of indemnity payments (69%) were made in cases involving intraoperative complications, and the remainder of payments were made in "wrong" cases.

Postoperative need for glasses

The small number of cases in this category (5) may be attributable to a thorough informed consent discussion and use of a cataract-specific consent form, signed by the patient and retained in the medical records. Preoperatively, two patients were insistent on a no-glasses surgical goal, even though both surgeons documented that pre-existing conditions made this unachievable. The other two patients signed a cataract-specific consent form that documented the possibility that glasses would be needed postoperatively. No indemnity payments were made in this category.

Wrong events

Five of the six cases in this category involved implantation of the wrong power lens; one case involved implanting a different lens than the one agreed upon during the informed consent discussion. Misfiled documents, communication of the wrong measurements from the surgeon's office to the ASC, and a surgical planning form that was inconsistent with the surgical plan in the chart were responsible for three of the wrong power cases. These claims settled for amounts between $20,000 and $50,000. In the other two cases, technology failures may have been responsible for incorrect measurements. One of these cases settled for $30,000 and the other was closed without indemnity after being denied by a pre-litigation panel.

In the one wrong type case, it was never discovered how or why the original surgical plan for monofocal lenses was replaced with a multifocal IOL in each eye in procedures performed just three days apart. The patient failed to adjust to the multifocal IOLs, Yag capsulotomy did not improve her symptoms, and subsequently an IOL exchange was performed by a different surgeon. The patient noted in her complaint that staff at the practice had recommended and encouraged multifocal lenses for each eye. The expert opined that although the surgical plan was not carried out, multifocal IOLs were not contraindicated. The patient's monetary demand was declined.

Risk Management Checklist

√ Confirm measurements prior to sending to ASC.

√ Changes in surgical plan: revisit consent; discuss with patient; document.

√ Confirm lens type and power against medical record and patient prior to implantation.

√ Intraoperative changes in plan: use a time out to resolve; document; advise patient.

Billing Issues

The role of insurance coverage in the context of premium IOLs and services was a source of patient confusion in nine cases and led to complaints to state medical boards, insurance carriers, or small claims courts. Some patients lodged complaints with all three entities. None of the claims resulted in an indemnity payment, and total expense payments were relatively low ($22,271). An additional layer of confusion occurred in two cases when the surgical plan changed following the consent discussion, either by the patient or because of anatomical findings during surgery. These patients, who had paid for premium lenses and services, voiced confusion and asked if they had "gotten what they paid for."

Negotiating resolution of these disputes requires extra time for physicians and office staff, is stress-inducing, can negatively impact the patient-physician relationship, and may even damage the physician's reputation. To wit, one patient threatened to post an accusation of fraudulent billing on social media, even though the physician was ultimately found to have billed appropriately.

Insureds used patient information sheets that explained out-of-pocket costs and what insurance typically covers, which patients signed. Billing records showed descriptions of what each fee covered. Nevertheless, patients did not always remember the content of these documents.

Risk Management Checklist

√ Clear communication and documentation of out-of-pocket fees and what will be billed to insurance is paramount. Provide the patient with a copy of the breakdown of fees and maintain a copy in the record.

√ Discuss changes to the surgical plan and treatment of complications, and how that impacts what the patient has already paid or may need to pay.

Postoperative Visual Acuity

This category was assigned when the patient's primary dissatisfaction with the surgical outcome occurred in the absence of a known error in measurements, a wrong event, or complication at surgery. It is the second largest category involving 16 cases, of which 3 were lawsuits. In 13 of the 16 cases, a cataract-specific consent form was used. In the 14 cases where medical records were available, all revealed adequate to excellent documentation of a preoperative discussion regarding lens options and risks, benefits, and alternatives. None resulted in an indemnity payment.

Three patients were convinced that wrong lenses had been implanted. A medical condition contributed to poorer visual acuity postoperatively in three other cases: prior LASIK surgery, a history of optic neuritis, and failed neuroadaptation to multifocal lenses. In the other instances, patient complaints appeared to stem from expectations that vision would be better (sharper and clearer) and frustration with ongoing halos and floaters. In one lawsuit, the plaintiff testified at deposition that the insured had failed to disclose the potential postoperative complications she was experiencing. After refreshing plaintiff's memory with the consent forms she had signed that discussed those complications, plaintiff acknowledged that she did not ask the surgeon any questions and probably did not read the consent forms. The suit was later dismissed by plaintiff.

2A. COST OF DEFENDING CATARACT CLAIMS (2016-2020)			
Type	Claims	Expenses	Indemnity
All cataract claims	299	$3.60M	$8.16M
ONLY premium IOLs and services	99	$964,000	$3.42M

2B. ONLY PREMIUM IOL AND SERVICES (2016-2020)	
# claims closed with indemnity	13 (13%)
Mean indemnity payment	$263,077
Indemnity range	$3k to $1M

Risk Management Checklist

√ Consider using the teach-back method if patients have no questions. Ask patients to tell you in their own words what the surgical goals mean for their vision, and how it will impact ADLs, such as reading, driving, favorite activities, etc.

√ Set realistic expectations about neuroadaptation to multifocal IOLs.

√ Supplement your consent discussion and procedure-specific consent form with other educational tools, such as videos.

Complications at surgery and postoperatively

This final category contains the largest number of cases (42) and accounts for 96% ($3.27M) of the $3.42M indemnity paid for all claims in the study. Thirteen cases were litigated and seven incurred indemnity payments ranging between $100,000 and $1M. Two of the 29 non-litigated claims resulted in indemnity payments of $15,000 and $3,000. (Complication details shown on back page of this *Digest*).

The intraoperative complications in this category are known risks of cataract surgery, although HORV (hemorrhagic occlusive retinal vasculitis) and death from oculocardiac reflex are rare. Seven cases (six suits and one claim) were settled due to postoperative management of the complications.

In the two suits alleging damages from capsular rupture, defense experts were critical of delayed referral when the retina could not be visualized at the first postoperative visit. In the other suit, experts opined that the insured should have performed a dilated exam due to patient's sensation of a hair-like object in her vision, which the surgeon attributed to the newly-implanted IOL. Ultimately the patient was diagnosed with a macula-off retinal detachment. Experts were critical of failure to document key discussions with the patients regarding signs of retinal detachment.

In the suit involving Intraoperative Floppy Iris Syndrome, experts supported the insured's care and treatment but were critical of failure to document the complication in the operative report. Ultimately the patient's visual acuity was 20/20 and 20/25, but was compromised due to peripheral haze caused by the transillumination defect in the left eye.

In the HORV case, tri-moxy-vanc was used bilaterally in cataract surgeries performed 2 weeks apart. Both procedures were performed prior to the FDA statement admonishing physicians to stop using vancomycin. The patient signed a cataract-specific consent that disclosed the risks of blindness and death. Plaintiff alleged that the insured should have postponed the second surgery due to the patient's report of flashes of color and evaluated the retina, which presumably would have led to earlier treatment and a better outcome. However, defense experts opined that earlier intervention may not have prevented bilateral blindness.

In the oculocardiac reflex case, our insured was listed as the physician supervising the attending CRNA. The surgery center did not have an anesthesiologist immediately available. The patient, who had significant comorbidities, was cleared for surgery by an on-site PA. The patient coded intraoperatively and expired five weeks later. Experts were supportive of the ophthalmic portion of the case, but criticized the quality of the anesthesia notes and patient monitoring. It was later discovered that the anesthesia warning alarms had been turned off and the oximetry leads had become disconnected from the patient.

The 13 cases of postoperative complications involved three risk management issues: delayed diagnosis, delayed referral, and inadequate documentation. Experts opined that postoperative management of cataract surgeries with complications, and inability to visualize the fundus on postoperative day one, require evaluation by dilated exam or B scan, or prompt referral to retina. Three cases of delayed diagnosis and referral resulted in macula-off retinal detachments with vision loss. Experts agreed the loss of vision was directly related to the delay, and the outcomes could have been improved by earlier treatment. One patient became legally blind in one eye due to the delay.

Risk Management Checklist

√ Disclose any intraoperative changes to the surgical plan and complications to the patient in a timely fashion; document the discussion and treatment plan in the medical record.

√ Make sure the final operative report is accurate. Document the complication objectively.

√ Stay current with anesthesia guidelines for preoperative testing and risk factors to identify high-risk patients and reschedule their surgeries to include an anesthesiologist, and perhaps switch to a hospital setting. Document this process.

√ Intraoperative complications and postoperative sequelae should be promptly addressed with appropriate clinical evaluation and intervention. Maintain a high index of suspicion for complications, determine a follow-up plan, and document the record accordingly.

√ Surprise residual refractive error may necessitate repeat A-Scan biometry OU and/or delay of surgery on second eye.

Conclusions

Premium intraocular lenses and those services associated with their use create unique circumstances that can increase the risk of patient dissatisfaction and claims. Out-of-pocket expenses, advertising, referral sources, the experiences of the patient's friends and family members, and frustration with preexisting refractive needs can raise patient expectations to unrealistic levels. Adding increased patient demand for expedited surgery while worrying about possible COVID-related delays could increase such risks as perceived miscommunication and suboptimal calculations. How do we best handle these increased demands? The answer is carefully, professionally, and ethically prioritizing safe and appropriate patient care. We have the knowledge and expertise to engage patients in a thorough informed consent process that advises them of their lens choices and manages expectations. Clear communication and documentation also aid the surgeon in achieving accuracy of measurements and resulting refraction. All this adds up to increased patient satisfaction and reduced professional liability.

CLOSED CLAIM STUDY

Chart alteration hinders the defense of a complicated cataract surgery

RYAN M. BUCSI, OMIC Claims Vice President

Allegation

Failure to timely diagnose endophthalmitis following complicated cataract surgery resulting in enucleation in a then 78-year-old male.

Disposition

Settled for $750K, split between insured group and insured.

The patient presented to an OMIC insured group for evaluation of bilateral cataracts with an OMIC insured. He had a history of difficulty reading small print, seeing in bright sunlight, and glare at night. A dilated exam revealed significant amblyopia OS, with BCVA of 20/100 and a modest cataract OD with BCVA of 20/30. It was decided that cataract surgery OD would be performed.

The surgery was complicated by a floppy iris and iris prolapse, which required iridectomy and placement of sutures in two separate corneal incisions. On postoperative day one, the insured documented that the patient reported pain the previous night, with blurry vision. The insured also documented swelling to and around the patient's cornea. Postoperative drop instructions were reviewed with the patient and the caregiver. The patient was instructed to return to the office the following Monday and to call the insured with any increased redness, increased pain, or decreased vision.

On Saturday, the patient's caretaker called the insured and reported that the patient was feeling tired with no further changes in regards to vision, pain, or redness. The insured informed the caretaker that the Diamox can cause tiredness and offered see the patient in the office, but the caretaker declined. The patient was again advised to call with increased pain, decreased vision, or redness.

When the patient returned on Monday an obvious infection was present. The patient was immediately referred to an oculoplastic and retina specialist where he was treated with IV antibiotics. An eye culture revealed Citrobacter koseri resulting in panophthalmitis. Five days later, an enucleation was performed and the patient was eventually fitted with a prosthetic implant.

Analysis

Plaintiff expert opined that the patient was not a candidate for cataract surgery in his "good" right eye where the BCVA was 20/30, since the patient had amblyopia in the "poor" left eye. Plaintiff expert also opined that, based on the insured's documentation on postoperative day one of swelling and decreased vision, an infection was already present.

There was a discrepancy between how the insured and the caretaker described the Saturday phone call. However, after the way the insured described the eye on postoperative day one, the plaintiff expert opined that he was relying on common sense that the caretaker was indeed calling to report increased pain, increased redness, or decreased vision. Likewise, the defense experts could not support the postoperative care as they believed the insured should have requested to see the patient following the Saturday telephone call instead of leaving the decision to the patient and caretaker.

The plaintiff expert was critical of the insured for altering a chart note without noting it as a late entry and that it was inappropriate for the insured to document the caregiver phone call in his personal computer notes versus the patient's chart. The late entry described the caregiver bringing in medication bottles where the cap was missing from the Besivance antibiotic drops. Plaintiff counsel interpreted this note as an attempt by the insured to blame the patient for the infection after the fact.

Our defense experts could not effectively counter plaintiff expert's opinions. Without experts to support the care of the insured, the case was settled for $750K.

Takeaway

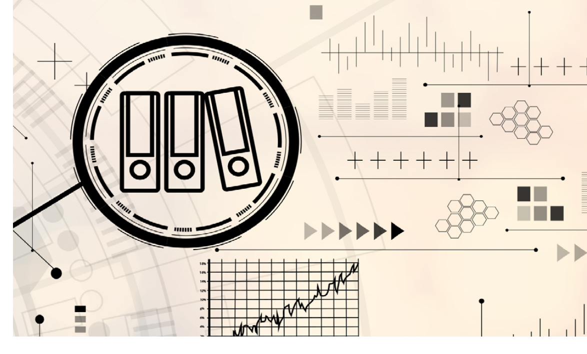
With no supportive experts on the standard of care and an insured that lacked credibility, the defense considered admitting liability and trying the case solely on damages. The jury would not have heard any aspects of the case, but would have been tasked only with determining the amount of money to award the plaintiff based on the damages. This strategy prevents the jury from hearing facts related to substandard care that could anger them and lead to an excessive verdict. However, it was ultimately decided to attempt settlement in this case, which was accomplished.

Credibility is essential in successfully defending a lawsuit. When chart notes are altered or made outside the patient's chart, this significantly decreases the credibility of an insured. Such chart alterations and outside notes after an adverse outcome look suspicious, self-serving, and arouse suspicion that the insured was trying to cover something up or rewrite history. This can hinder the defense of a case and leads to increased settlement value.

RISK REDUCTION STRATEGIES

Analysis of the cataract study

MICHAEL TIGANI, MD, OMIC Risk Management Committee Chair and
RON W. PELTON, MD, PHD, OMIC Director and AAO Ethics Committee Chair



Over the last two years, OMIC has seen an increase in the frequency of cataract surgery claims. In response, Risk Management performed an in-depth analysis of 2016-2020 claims involving premium cataract services and our findings are detailed in the lead article.

Drs. Tigani and Pelton discuss some additional factors that may set the stage for vulnerability to cataract claims activity.

Patient Pressure

Dr. Tigani: Cataract surgery volume surged as pandemic-delayed cases were rebooked once patients became vaccinated and practice restrictions were lifted. Some patients now worry if a second wave will further delay their elective procedures. Postponing surgery to treat tear film abnormalities and repeat biometry measurements often ensures a better outcome, but ophthalmologists need to explain this to patients who have waited for their COVID-19 vaccine and now want surgery as soon as possible. Patient pressure should not supersede prudent medical decision making.

Patient Expectations

Dr. Tigani: Most importantly, we must manage our patients' preoperative expectations, which are heightened by several factors, from initial enticements in advertisements and promotions to confusion about how different lenses work, lens adaptation, and out-of-pocket expenses.

There is no shortage of information available about technical advances in IOLs, and ophthalmologists are fortunate to have such an array to offer our patients. However, the process of cataract surgery and lens implantation presents a set of complicated decisions for the patient set against that backdrop of high expectations. The ophthalmologist, with his or her experience and knowledge, has the duty – and the opportunity – to make this process more digestible and realistic for the patient during the informed consent process. The time the surgeon spends with the patient may reveal new "red flags" such as persistent indecisiveness or continued lack of understanding of a chosen IOL's vision enhancements and shortcomings. Ophthalmologists also must be aware of co-management referral sources who send patients with the expectation of a premium lens when, in fact, some of those patients may have pre-existing conditions – severe dry eye, macular pathology, corneal disease, or visual field loss to name a few, that guarantee unmet expectations. It is the surgeon's responsibility to examine the patient and explain why a certain lens may or may not work, including the infrequently discussed aberrations and shortcomings of each lens option. That surgeon time can also strengthen the patient's trust and confidence in the physician-patient relationship.

The ophthalmologist also must be attentive to nuances that can alter preoperative calculations and result in postoperative patient dissatisfaction, whether it be residual refractive error or perceived IOL performance issues.

Conflicts of Interest

Dr. Tigani: Each year, insurance reimbursement for cataract surgery reaches a new low. Premium IOL surgery assists the cataract surgeon in maintaining an income stream vital to their practice. However, ophthalmologists must separate the practice's financial benefit from the patient's safety, clinical need, and satisfaction. Providing incentives to staff for premium IOL conversion could increase the likelihood of postoperative patient dissatisfaction and subsequent claims.

Dr. Pelton: The primary tenet of the American Academy of Ophthalmology's Code of Ethics is "always do what is in the best interest of the patient." The ophthalmic surgeon has both an ethical and fiduciary duty to the patient, so when the potential exists for a conflict of interest in patient care because of financial concerns, it is essential that the surgeon recognizes the conflict and takes steps to ensure that does not interfere with appropriate care.

To protect the patient's autonomy in making informed decisions for surgery, the surgeon should ensure that all aspects of premium IOL use (cost, risks, benefits, alternatives, etc.) are carefully and dispassionately explained in detail to the patient by the surgeon and NOT by a surrogate.

AAO Ethics rules concerned with premium IOL use are: 2. Informed Consent; 9. Medical and Surgical Procedures; 11. Commercial Relationships; 13. Communications to the Public; and 15. Conflict of Interest. **(see aao.org/ethics-detail/code-of-ethics)**

Takeaway

Could these factors – patient pressure, patient expectations, and conflicts of interest - combine to fuel a larger number of claims? Not if ophthalmologists adhere to the principles of safe patient care and the professional guidelines they have incorporated into their practices over the years. Individualized care and application of sound risk management measures will prevent mistakes in communication, errors in lens calculations, and improper lens selection in the majority of cases.

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RISK MANAGEMENT

OMIC offers several online courses. Insureds receive a risk management premium discount for participation. Contact Linda Nakamura at 800.562.6642, ext. 652, or lnakamura@omic.com, for questions about OMIC risk management options or learn more at omic.com.

Home Study

For a complete listing of current recordings and computer-based courses available for OMIC insureds, visit omic.com/risk-management/education/online-and-recorded-courses.

Live Seminars

OMIC will conduct live courses again when it is safe to do so. A listing of upcoming courses will be posted at omic.com/calendar.

Partnerships

OMIC has partnerships with most ophthalmic societies in the United States.

Members of state, subspecialty, and special interest societies that partner with OMIC receive special discounts when they participate in our risk management program.

Learn more at omic.com/partners.

Alerts and Bulletins

OMIC posts recommendations for responding to recalls and alerts. For a complete archive visit omic.com/risk-management/digests-alerts-and-bulletins.

LEAD ARTICLE RESOURCES

OMIC and the American Academy of Ophthalmology offer several online resources to assist ophthalmologists.

OMIC Library

For a complete online library of forms, documents, and recommendations, visit omic.com/risk-management/ophthalmology/cataract

OMIC Hotline

OMIC's confidential hotline is available for insureds who need assistance. Call (800) 562-6642 and Press 4 for the risk manager on duty. Message the hotline at riskmanagement@omic.com

AAO Store

The AAO store has excellent patient education videos on a variety of topics. For specific videos related to cataract surgery visit store.aao.org/cataract-and-refractive-surgery-patient-education-video-collection.html

TABLE 3.
TYPE OF COMPLICATION BY FREQUENCY AND INDEMNITY

Complication	# of cases	# of suits	Indemnity paid
Lens malposition/displacement	5	1	$165,000
Capsule tear/rupture	5	2	$1.25M
Corneal abrasion	4	0	
IFIS (intraocular floppy iris syndrome)	3	1	$100,000
Refractive surprise	3	2	$3,000
RD (retinal detachment)	3	1	$250,000
Uveitis	3	2	
CME (cystoid macular edema)	2	0	
DES (dry eye syndrome)	2	0	
Dropped nucleus	2	0	
ARMD (age-related macular edema)	1	1	
Endophthalmitis	1	0	
Epiretinal membrane revealed	1	0	
HORV (hemorrhagic occlusive retinal vasculitis)	1	1	$500,000
NAION (non-arteritic anterior ischemic optic neuropathy)	1	0	
Negative dysphotopisia	1	0	
Oculocardiac reflex (death)	1	1	$1M
Rent in prior RK incision	1	0	
Z syndrome	1	1	
Zonular laxity precluded planned toric lens implant; required 2nd procedure	1	0	
TOTAL INDEMNITY			$3.27M