Defending Ophthalmology
Malpractice Suits

Why similar-type cases come in waves.

By Neil H. Ekblom, Esq.

Wave theory originated in quantum physics as an elegant way to describe the properties and movement of light, sound, atoms and, eventually, all forms of energy. The underlying thesis migrated to the world of finance in postulations such as the Elliott Wave Theory, which holds that there are repeated, predictable patterns in market pricing. Most recently, social scientists have been applying wave theory to everything from the spread of democracy to the growth of terrorism. Based on my 20 years experience defending physicians in ophthalmology lawsuits, I'd make the argument that a wave theory exists in the area of lawsuits filed against ophthalmologists and that understanding those waves can help practitioners and their attorneys better prepare to defend against such suits, both actual and potential.

A Shifting Pattern of Lawsuits

The driving forces behind a wave of lawsuits vary over time, but are generally easy to identify. For example, advances in technology, changes in resident and fellowship training, and the state of the economy all influence the types of cases brought before the courts. One of the best illustrations is the wave of LASIK lawsuits that began in the 1990s.

When a stronger economy broadened accessibility to LASIK among consumers with the disposable income available to spend on the procedure, claims skyrocketed. At the same time, standards of care were still being developed for this highly specialized practice, which also contributed to a jump in the number of claims. The early cases were for PRK initially, and then the off-label use of LASIK, representing two crests of the wave. At first, night vision complaints accounted for the majority of cases, but as physicians advisedly began using comprehensive informed consent forms, this wave ebbed, and these types of cases began to be displaced by other claims, including pupil size, buttonholes, decentered flaps and ablations, difficulties in treating high myopia and high astigmatism and, of course, ectasia.

Currently, this wave has receded, and the volume of LASIK cases is down, with most remaining cases now claiming post-LASIK ectasia. Plaintiff attorneys in ectasia cases often argue that not only was the doctor negligent by failing to discern the most subtle of indications on topography, but that the entire LASIK industry is fee-driven and careless.

This argument is designed to maximize the verdict in order to punish LASIK surgery rather than simply redress a claimed injury. Therefore, LASIK surgeons must be meticulous in their office procedure, consent forms and how they satisfy patient expectations. Many LASIK claims can be avoided through pre-suit general releases, allowing physicians to refund fees or to pay for treatment when patients express unhappiness with the outcome. If refractions indicate truly poor outcomes, a stipulated refund of a few thousand dollars for treatment is an excellent way of avoiding future ectasia cases that might require very high sums to settle.
What the Plaintiffs Claim

The wave of post-LASIK ectasia cases often are based on claims of improper candidacy, given the scope of information available to the practitioner at the time of the evaluation. Plaintiffs usually claim that something was a red flag in candidacy evaluation, including best-corrected visual acuity, clinical exam, keratometry, pachymetry and topography. The malpractice claim is usually accompanied by a lack of informed consent claim. Typical claims include:

► That the informed consent form was overly technical and could not be understood.
► That the consent form was not given to the patient until the day of surgery, and its content was therefore not appreciated.
► That an employee told the patient that the consent form was merely a formality.
► That the patient received a sedative before reading and signing the consent form, thus rendering the consent invalid.
► That LASIK is a conveyor-belt process and lacks meaningful preop or postop evaluation by the refractive surgeon, with such evaluation instead done by inappropriately trained subordinates such as optometrists and technicians.
► That something was missed during the evaluation of the refraction, the keratometry readings, the clinical exam (including slit lamp), the pachymetry or the topography.
► That a subtle finding on preop topography represented forme fruste keratoconous (FFKC).

There are plaintiffs' experts who claim at trial that FFKC can always be diagnosed preop, despite recent articles in peer-reviewed journals from well-known refractive surgeons claiming otherwise. Currently, there are far fewer LASIK cases than there were five years ago when such cases represented a high percentage of ophthalmology lawsuits.

A New Wave of Claims

A similar phenomenon is evident in the wave of vitreoretinal cases that have been filed since 1990, perhaps because more vitreoretinal surgeons are using proactive intervention to save vision and have the tools and the training to do so. In fact, many vitreoretinal specialists are facing multiple lawsuits. Typically, plaintiffs sue both the anterior segment surgeon and the vitreoretinal surgeon, a strategy that obviates the potential for one to blame the other for the loss of vision if both were not sued. When reattachment of the retina fails, concepts such as vitrectomy, cryotherapy, scleral buckle and PVR must be defined and explained to jurors. Approximately one of every three cases we see today is a retina case, and virtually none involve true malpractice, just less-than-ideal outcomes stemming from the patient's status upon arrival at the retina surgeon's office.

While LASIK cases have abated somewhat, the volume of vitreoretinal cases remains fairly constant. However, the bulk of defense assignments and referrals most recently are for cataract and vitreoretinal surgeries — the “next wave” in ophthalmology lawsuits, so to speak.

Cataract Cases and Their Defense

The overall volume of cataract cases has remained fairly steady in recent years, but the wave theory is evident in the incidence of complications associated with phacoemulsification. For example, a relatively small number of Flomax cases have been filed since articles about floppy iris syndrome began appearing in newspapers nearly four years ago, but fewer suits have been brought in subsequent years. These cases are defended with good operative reports that indicate iris hook or the Malyugin Ring were used proactively, visibility was adequate to phaco and an IOL was inserted.

There is a set of common claims associated with phaco cases, including phaco burns (but less frequently than in the past), dislocated IOLs, retrobulbar issues, dropped nucleus and the occasional case of endophthalmitis. Dislocated IOL cases are brought on a consistent basis, perhaps because of problems associated with the alternative AC IOLs and the preference for in-the-bag or sulcus fixation. Common claims in these dislocation cases are that the surgeon failed to opt for an AC IOL or to sew in an IOL, two options that are sometimes worse from a medical standpoint and for which the surgical judgment can be defended in any case.

Strange as it may seem to most of today's US cataract surgeons who exclusively do phaco, some extracap procedures continue to be performed in certain large cities. With the steep drop in volume, malpractice suits involving extracaps have
declined to a point where the number is nearly negligible. Still, such litigation continues. We have become involved in cases where doctors ran into complications after switching from a planned phaco procedure to extracap. In New York, we see these cases at city-run hospitals and in situations where private surgeons are faced with a hard or mature lens. Complications include iris prolapse, endophthalmitis and suprachoroidal hemorrhage. In extracap iris prolapse cases, the plaintiff's argument is usually that the doctor has exposed the patient to an archaic procedure and its complications. Of course, as previously noted, phaco has its own set of complications, but juries seem to be swayed by the "archaic procedure" argument together with the claim of poor suturing.

The “Evergreen” Complaints

Some lawsuit precipitators appear to be unaffected by wave theory. For example, endophthalmitis and ocular melanoma cases occur regardless of lawsuit trends. The claims in the former include that the surgeon failed to prophylactically protect the patient at the end of the surgery with a proper broad spectrum antibiotic, and that the surgeon failed to discern the infection from the signs and symptoms presented postop.

The issue as to whether to perform a tap and inject or vitrectomy plus injection has not yet come up in our cases. In melanoma cases, the claim is either the failure to perform a dilated indirect examination with sufficient frequency in order to discover changes in a nevus or the failure to refer the patient to a specialist once nevus changes occur.

Claims are not common in the oculoplastic area, but they do not seem to be influenced by economic factors when they are filed. They may be outliers in terms of wave theory. Plaintiffs in this area often complain that they were not aware of the extent of surgery before the procedure, and that they do not like the results postop, including the lack of symmetry and other more subjective complaints.

These cases can be defended with good informed consents and pre- and postop professional photography that clearly captures all angles. The plaintiffs usually have had eyelid surgeries by several physicians, including both plastic and oculoplastic surgeons. The cases are difficult for plaintiffs to prosecute because their dissatisfaction often appears to be generalized and not directly attributable to any deficient or inadequate action or treatment on the practitioner's part.

A common claim seen in the glaucoma specialty is allegation of failure to aggressively move from medication to surgery. Some physicians are less aggressive when the diagnosis is in doubt and the risks high. Care in this field requires cooperative patients who can take medications, accept dilation and sit for visual fields. It seems the less-cooperative patients get the least-satisfactory results and they often end up blaming the specialist.

Other claims that have been brought against ophthalmologic specialists in varying numbers at different times over the past two decades include retrobulbar anesthesia complications, causing hemorrhage or perforation; improper treatment of corneal abrasions; improper treatment of corneal trauma; failure to diagnose aneurysms, causing loss of vision; failure to diagnose temporal arteritis, resulting in loss of vision and various oculoplastic claims.

Plaintiffs “Play the Lottery”

A highly respected New York Supreme Court Judge once privately opined that plaintiffs' ophthalmology cases were, more often than not, “losers.” He had already adjudicated four trials to a defense verdict, each sharing the same story: a sympathetic plaintiff loses vision in an eye during a routine procedure and subsequently sues the surgeon for big money damages. Yet, despite the records of good defense lawyers practicing in this area of specialty, defending ophthalmology cases too often boils down to facing off against plaintiffs who are “playing the lottery” by simply chasing the big verdict — apropos of the judge's observation.

Many plaintiff attorneys appear to operate from the perspective that they only need to win one case in three. Because that verdict more than pays for their work on the other two, high volume has become the mantra in this field of law over the past 20 years and an important factor in keeping those waves flowing.

Regardless of the type of claim an ophthalmologist is facing, there is another powerful wave theory at play here. It is the one recurrent pattern that persists in a successful defense: the involvement of an interested and helpful client who is available to the defense attorney and prepared for trial. Unfortunately, defending medical malpractice cases in this area
requires a substantial investment on the part of the physician in the form of significant time spent helping the attorney prepare and defend the case. The physician must also be prepared to attend the trial and, ideally, assist the attorney in preparing for cross-examining the plaintiff’s expert.

No matter how skilled a defense attorney is in conducting trials, input on the medical issues involved is always required to prevail in these cases. And the relevance of that truism is not a wave at all. It's a constant. OM

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