

Supplement to

Cataract & Refractive Surgery TODAY

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Lawyers, Guns, Money, & Medicine

A MEDICOLEGAL ROUNDTABLE:

Leading ophthalmologists and attorneys discuss the current legal environment in ophthalmology, recent personal legal experiences, and related medicolegal issues.

Stephen G. Slade, MD (Moderator)

John F. Doane, MD

Daniel Ryan, Esq

Adam Krafczek, JD (CoModerator)

Eric D. Donnenfeld, MD

James J. Salz, MD

Stephen F. Brint, MD

Lee T. Nordan, MD

Mark Speaker, MD, PhD

Stephen Coleman, MD

John Potter, OD

William B. Trattler, MD

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Lawyers, Guns, Money, & Medicine

BY STEPHEN G. SLADE, MD, MODERATOR, AND ADAM KRAFCZEK, JD, CoMODERATOR

Welcome to *Cataract & Refractive Surgery Today's* first annual medicolegal roundtable discussion. For surgeons, medical malpractice is a real-life issue that cannot be ignored. Once you are sued or even threatened with a malpractice lawsuit, lawyers, "guns," money, and medicine are all immediately implicated. *Lawyers*—you will need to formally retain one to defend you. "*Guns*"—you have a quick decision to make: do you prepare to do battle by retaining an attorney who comes out with guns blazing, defending your interests by litigating your case to the bitter end of a jury trial (which can often take years)? Or, after assessing your options, do you offer to settle? *Money*—what nearly every lawsuit comes down to. Once you are sued, regardless of the outcome, the dollars quickly add up from defense costs, attorneys' fees, time away from your practice, and monetary damages sought by the plaintiff (often millions these days). How much will your malpractice policy cover? Is there an issue of excess liability, and are your personal assets at risk? Finally, *medicine*—you will need to ask yourself, and discuss candidly and extensively with your attorney, whether you did in fact deviate in any way from the standard of medical care. If not, can you prove this at trial, and will a jury of your peers ultimately agree with you? These are just a few of the issues our panelists openly discuss in this roundtable.

When faced with a malpractice lawsuit, fear of the unknown makes you uneasy about the entire experience. There is no textbook, educational class, or Internet site that will tell you how to proceed with your case. Each case rests upon its own unique set of

facts and circumstances, and no one holds the figurative crystal ball. As you read the following roundtable discussion, keep a few points in mind. (1) Not all practicing physicians will be fortunate enough to entirely avoid legal confrontation throughout the duration of their careers. (2) If you face a malpractice suit, real or threatened, take advantage of the wealth of knowledge and advice available from your colleagues, trained legal professionals, and risk management experts. (3) Get involved and stay involved throughout the entire legal process of your defense. (4) When facing a malpractice suit, there are no right or wrong answers about how to proceed. You will simply have to face the many hard questions raised and discussed herein by our panelists. In the end, the right mix of *lawyers*, "*guns*," and *money* may just get you out of this. ♦

Stephen G. Slade, MD, is in private practice at the Slade & Baker Vision Center in Houston and is Co-Chief Medical Editor of refractive surgery for Cataract & Refractive Surgery Today. He has served as a defense expert in numerous medical malpractice actions. Dr. Slade may be reached at (713) 626-5544; sgs@visiontexas.com.



Adam Krafczek, JD, is Cofounder of Bryn Mawr Communications LLC, the publisher of Cataract & Refractive Surgery Today. He is also a civil trial attorney with the Law Offices of Adam B. Krafczek, with experience in a variety of specialties including health law and medical malpractice. Attorney Krafczek may be reached at adam@bmctoday.com.



Panel



Stephen F. Brint, MD, is Associate Clinical Professor of Ophthalmology at Tulane University School of Medicine in New Orleans. He is currently defending a case of corneal guttata that is awaiting medical panel review in Louisiana. Dr. Brint may be reached at (504) 888-2020; brintmd@aol.com.



Stephen Coleman, MD, is Director of Coleman Vision in Albuquerque, New Mexico. He was a named defendant in a 1999 PTK case that was settled out of court. He also successfully defended a 2-week jury trial involving an ectasia case in New Mexico during 2005. Dr. Coleman may be reached at (505) 821-8880; stephen@colemanvision.com.



John F. Doane, MD, is in private practice with Discover Vision Centers in Kansas City, Missouri, and is Clinical Assistant Professor for the Department of Ophthalmology, Kansas University Medical Center. He has reviewed and testified as a defense expert in numerous malpractice cases. Dr. Doane may be reached at (816) 478-1230; jdoane@discovervision.com.



Eric D. Donnenfeld, MD, is a partner in Ophthalmic Consultants of Long Island and is Co-Chairman of Corneal and External Disease at the Manhattan Eye, Ear, & Throat Hospital in New York. He has testified numerous times as an expert witness and has been involved directly in defending one case of LASIK in New York that went on to ectasia. That case is currently on appeal. Dr. Donnenfeld may be reached at (516) 766-2519; eddoph@aol.com.



Lee T. Nordan, MD, is a technology consultant for Vision Membrane Technologies, Inc., in Carlsbad, California. Before retiring in 2004, he testified as an expert witness in jury trials 15 times in state court and three times in federal court, for the defense 98% of the time and for the plaintiff 2%. He has given numerous depositions on keratorefractive surgery and cataract/IOL surgery. Dr. Nordan may be reached at (858) 487-9600; laserltn@aol.com.



John Potter, OD, is Vice President for Clinical Services for TLC Vision Corporation. He currently devotes his full time and attention to patient advocacy, dispute resolution, and conflict management in refractive surgery. Dr. Potter may be reached at (636) 534-2300; john.potter@tlcvision.com.



Daniel Ryan, Esq, is a partner with O'Brien & Ryan, LLP of Plymouth Meeting, Pennsylvania. His practice is dedicated substantially to the defense of physicians and healthcare institutions in complex professional liability claims. He has extensive experience in the representation at trial of surgeons and other health professionals. Mr. Ryan has lectured extensively on these issues, and he has made presentations at judicial conferences and to medical professionals. He has addressed medicolegal issues in the print and broadcast media as well. He has been elected as a Fellow of the American College of Trial Lawyers and serves as an Adjunct Professor at Villanova Law School. Attorney Ryan may be reached at (610) 834-6240; dryan@obrlaw.com.



James J. Salz, MD, is Clinical Professor, Ophthalmology, University of Southern California, Los Angeles; immediate past Chairperson of the ISRS/AAO; and on the Board of Directors and member of Claims and Risk Management Committees of OMIC. He has served as an expert witness in malpractice cases for both plaintiffs and defendants for more than 20 years. Most recently, he acted as the expert for a surgeon in a LASIK case complicated by diffuse lamellar keratitis (DLK) where the patient sustained minimal loss of vision. The insurance carrier encouraged the surgeon to agree to a settlement before jury deliberations were initiated. Dr. Salz may be reached at (310) 360-0609; jjsalzeye@aol.com.



Mark Speaker, MD, PhD, is in private practice in Manhattan and is Medical Director of TLC Laser Eye Centers in Manhattan. He is also Clinical Associate Professor of Ophthalmology at New York Medical College. He has served as an expert witness and was involved in an ectasia case in New York that resulted in a plaintiff's verdict after a jury trial in 2005. Dr. Speaker may be reached at lasikspeak@aol.com.



William B. Trattler, MD, is a corneal specialist at the Center for Excellence in Eye Care in Miami and a volunteer assistant professor of ophthalmology at the Bascom Palmer Eye Institute in Miami, Florida. He has served on the faculty of the ASCRS' Course on Medical-Legal Issues in Refractive Surgery and is currently serving as a defense expert in a number of medicolegal cases. Dr. Trattler may be reached at (305) 598-2020; wtrattler@earthlink.net.

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THE CURRENT LEGAL ENVIRONMENT IN OPHTHALMOLOGY

Dr. Slade: Dr. Salz, as a member of the Claims and Risk Management Committees of the Ophthalmic Mutual Insurance Company (OMIC; San Francisco, CA), can you introduce this roundtable discussion with a brief summary of the current medicolegal environment based on recent data from OMIC?

Dr. Salz: OMIC has a lot of useful data that illustrate the state of today's ophthalmic medicolegal environment. For example, the Physician Insurers Association of America (PIAA; Rockville, MD) has data regarding ophthalmology's ranking in terms of total number of malpractice claims, total indemnity paid, and average dollars paid per claim compared with other specialties between 1985 and 2004 (data on file with PIAA). With 6,000 claims (average paid, \$168,000), ophthalmology fell between the highest-ranked specialty, OB/GYN, at almost 30,000 claims (average paid, \$258,000) and the lowest-ranked specialty, oral surgery, at 62 claims (average paid, \$28,000).

In talking with colleagues about malpractice insurance rates, many of those not performing refractive surgery suspect that they are subsidizing refractive surgery and should be paying a lower insurance premium, but this is not the case. Figure 1 shows that between 2002 and 2004, the total number of cataract claims was greater than refractive surgery claims (the latter are about the same as for retina and general ophthalmology). A pediatric ophthalmologist looking at this figure might say (and they have) that that specialty's claim incidence is low and therefore should carry a lower premium. However, Figure 2 shows that

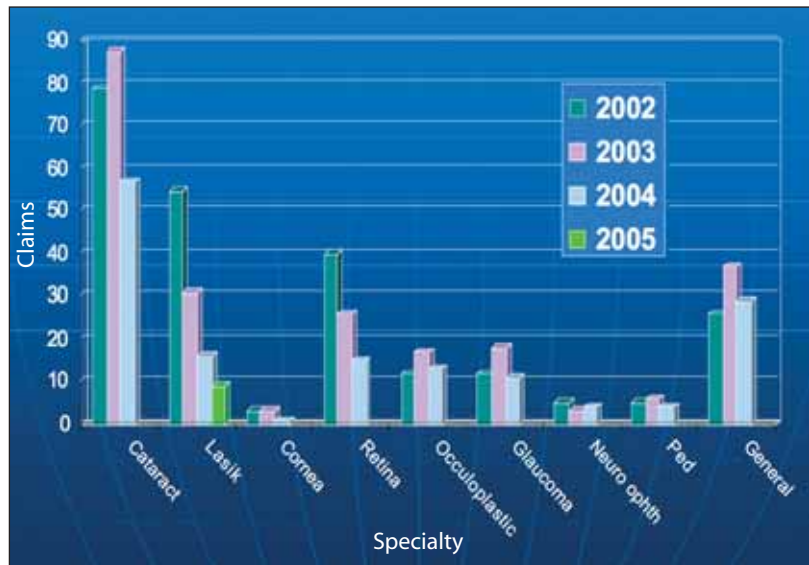


Figure 1. This graph shows OMIC's malpractice insurance claims by specialty, opened per year. It reflects data through July 1, 2005.

(Courtesy of Ophthalmic Mutual Insurance Company.)

although pediatric ophthalmologists had only 10 claims between 2001 and 2004, the average amount paid was over \$300,000 compared with 26 LASIK claims with an average paid of less than \$100,000 (Figure 3). So, the total amount of indemnity paid per specialty during that same time frame is more than \$3.5 million for cataracts, more than \$3 million for pediatrics, and slightly over \$2 million for LASIK (Figure 4). The winner (or loser might be a better term) was general ophthalmology, with over \$6 million paid. How can this be? For pediatrics, the awards are high for retinopathy of prematurity. For general ophthalmology, claims can include missed diagnoses that lead to death or serious disability (eg, brain tumors), which usually generate large awards. Most refractive surgery patients do not die or go blind. Even the most serious complications, such as corneal infections and ectasia, can be repaired with a corneal transplant. Of course, refractive surgery claims can lead to large awards because of economic damages, as in the well-publicized case of the pilot who claimed a loss of future earnings. He testified that he did not feel safe flying at night because of night vision complaints following LASIK, which he alleges were not emphasized as a significant risk factor in his informed consent discussion.

Incidentally, statistics show that OMIC's LASIK claims, which steadily increased between 1998 and 2002, decreased dramatically in 2006 (Figure 5). All practitioners should be encouraged by this finding.

Figure 6 summarizes OMIC's refractive surgery claims and cataract claims between 1995 and 2004. The number

of claims for radial keratotomy (RK) and photorefractive keratectomy (PRK) are surprisingly low, considering that RK is generally acknowledged as being nowhere near as good as PRK or LASIK in terms of accuracy or predictability. The reason for the procedure's low number of claims is that RK was the first widely accepted refractive surgery procedure and was not regulated by the FDA. Thus, there was no intense scrutiny of the procedure's results or complications and no standardized form of technique training. Surgeons who wanted to adopt RK simply took a course, observed another surgeon, or watched a video, then bought the instruments and started operating. Thus, some surgeons advocated optical zones as small as 2 mm and made as many as 32 incisions. OMIC required surgeons performing RK to fill out a questionnaire that asked, what is the maximum amount of myopia you will attempt to correct, the maximum number of incisions utilized, and the minimum optical zone you will use? OMIC deemed surgeons thought to be employing high-risk techniques as uninsurable. I am aware of many RK lawsuits, some resulting in large awards. The OMIC experience was favorable, because of the rigid underwriting guidelines the company adopted that caused surgeons employing high-risk techniques to be insured by other companies.

EXPERT WITNESSES

Dr. Slade: In your opinions, what role do expert witnesses play in the medical malpractice environment?

Dr. Salz: One of the more significant LASIK cases went to trial in Texas. It involved a probable thick flap that was not measured at the time of surgery. Both sides had good experts, but the jury found the plaintiff's expert more credible. The jury awarded the plaintiff \$900,000, despite the fact that there was nothing clearly abnormal about his workup or topography, and his cornea was thick enough for surgery. Theoretically, if the flap had been the thickness at which the keratome was set, there probably would not have been a lawsuit. Five years ago, however, ophthalmologists did not measure flap thicknesses routinely. As a result, the plaintiff prevailed, although I believe the case was defensible.

Dr. Slade: After the LASIK surgery, that patient involved in the Texas lawsuit was referred to me, and I performed his grafts. One aspect of that case that I did not understand was why the expert for the defense did not testify at the trial in person.

Dr. Salz: The defense attorney in that case decided to

present the expert's testimony by videotape rather than have him testify in person. The insurance company would have preferred that the expert testify in person. I know the attorney who handled the defense in that case, and I believe he is qualified, although I do not believe that that was a good decision strategically.

Dr. Potter: In my opinion, it is very important for the expert to testify in person. The presence of the medical expert in the courtroom is one of the physician's greatest assets in establishing their authenticity and credibility to a jury.

Dr. Salz: After being polled, the jury indicated that it was impressed with the defense expert's videotaped testimony and thought he was more credible than the plaintiff's expert. The jury concluded that the treating physician was inexperienced for the type of procedure in question. If the defense expert had been the one to perform the procedure, the jury stated that it would not have found liability.

Dr. Nordan: I believe that juries often make decisions based upon the emotional component of the case and do not pay particular attention to the technical aspect of the procedure. It is a question of whether the doctor cares about the patient and did all that could be done for him.

Dr. Trattler: Was the plaintiff's expert credible?

Dr. Salz: I believe that the plaintiff's expert was credible. In this particular case, it was not a clear-cut decision to proceed with the surgery. The surgeon referred the patient to a cornea expert for a second opinion, and that physician indicated that the surgery was viable. The patient's topography was normal, but the jury viewed the defendant as being unsure of his abilities because he asked for the second opinion! Due to his inexperience (the defendant had only performed 100 LASIK procedures prior to the one involving the plaintiff), the jury concluded that he was liable. Since there were no complications during surgery, when experience would be expected to make a difference, the jury's reasoning is difficult to comprehend.

Dr. Trattler: Did the plaintiff's expert ultimately offer an opinion that the defendant was negligent because he did not meet the appropriate standard of care?

Dr. Salz: The expert opined that the combination of the patient's borderline corneal thickness and borderline topography should have prompted the defendant to

inform the plaintiff that she was not the best candidate for this procedure. The defendant's failure to do so was deemed to be below the appropriate standard of care.

Dr. Potter: In my experience, a good plaintiff's attorney will sway the jury by convincing it that the doctor could have done something more for the benefit of the patient. The jury will not believe that a physician would have done something deliberately and willfully harmful to a patient. During the course of the trial, the plaintiff's attorney will plant in the jury's mind a seed of doubt that, if the doctor had just been a little more careful, he could have prevented the plaintiff from suffering loss of vision and other damages.

Dr. Donnenfeld: I disagree with that position. A jury believes that one doctor will not testify against another doctor unless the defending doctor has committed malpractice. When one doctor testifies that the other's treatment was not within the standard of care, the jury is going to believe that testimony, because there is no other reason for the doctor to testify against one of his colleagues.

Dr. Nordan: Actually, a defense expert can help reduce that concern by providing information to the defense attorney that can be used to discredit the testimony of the plaintiff's expert. I think that's where the gloves have to come off, with one expert going after the other. In my experience, I do not think the defense expert sufficiently guides the lawyer on how to discredit the plaintiff's expert.

Dr. Donnenfeld: I think the experts do a pretty good job, and I think the defense expert in this case performed well. As defense experts, we are there to tell the defense attorney what points to make in attacking the theory of liability put forth by the plaintiff's expert. The defense attorney can present those points to the jury to demonstrate why the testimony from the plaintiff's expert does not carry weight. This part of the defense attorney's job is very difficult. I think we physicians would do a much better job of informing the jury than the defense attorney. Unless you have an incredible defense attorney, and to be blunt, defense attorneys are often not as good as plaintiff's attorneys, you are not going to win the jury.

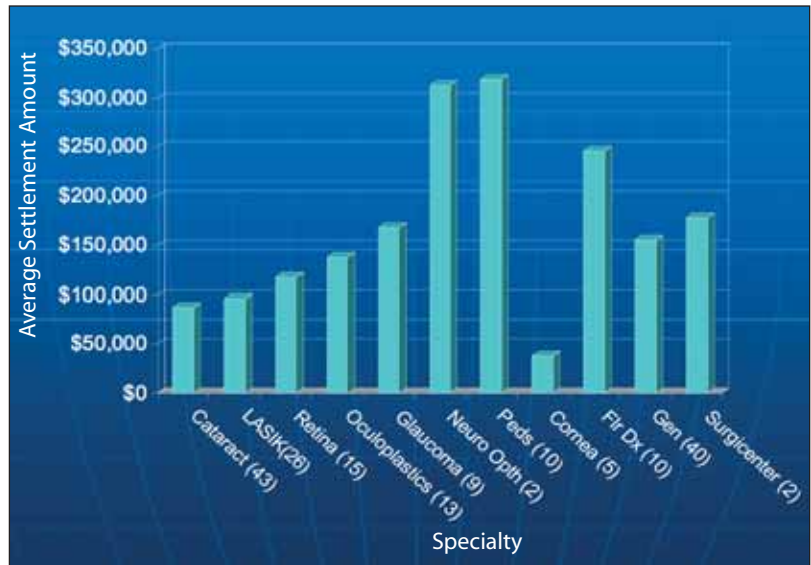


Figure 2. This chart shows OMIC's average malpractice settlement payment per specialty from 2001 to 2004.

(Courtesy of Ophthalmic Mutual Insurance Company.)

Dr. Potter: Over the past 2 years, plaintiff's attorneys have figured out a very effective strategy for winning malpractice cases, which I mentioned previously. They gradually push more weight on the physician, saying that if he had been a little more careful or a bit more diligent, then the plaintiff would not be suffering as much as he is. Juries listen to that argument.

In these times, if you wish to be an expert witness for the defense, you should be coached professionally, because all the weight of the argument is going to rest on your words. Some expert witnesses come across beautifully in the courtroom, but others are weaker. They may be great doctors, but they are not so great in a courtroom, often because they have not been coached for that role. To Dr. Salz' earlier point, the defense counsel often is not as prepared as the plaintiff's counsel, so the defense's physician expert must help the defense counsel understand the line of reasoning and the questioning that should take place.

Dr. Slade: How do you get the best defense expert?

Dr. Coleman: It is remarkably unlikely that most malpractice cases will see a courtroom. Correct me if I am wrong, but the overwhelming majority of these cases are settled. Therefore, let's not concentrate on the histrionics that go on in the courtroom. Most physicians will never walk into a courtroom.

When choosing an expert witness to defend your case, I think the key is to look for someone who is intuitive,

bright, confident, and presents himself well. He must have tremendous credentials, because in my experience, the defense expert is the sole barometer regarding the standard of care.

Dr. Slade: Dr. Donnenfeld, how did you pick your defense expert in your recent case that went to trial?

Dr. Donnenfeld: I personally called people who I knew would do a good job, and I think my defense expert did. I was there for his testimony, and I thought he communicated beautifully to the jury. He was convincing, and he spoke in lay terms. As someone who has served as a defense expert, I think the key is to communicate. I do not think that the expert's role is simply to present facts and quote literature. As an expert, I try to communicate in terms that the jury will understand, and I try to present myself as credible and willing to educate the jury. This form of communication is completely different from how I communicate with other ophthalmologists on the podium. When some experts get on the stand, they deal in minutiae and leave gray areas. I try to be convincing and communicate the truth in a way that the jury understands and that will allow them to see the fallacies of the expert witness on the other side.

Dr. Nordan: Another issue is that the members of the jury usually do not have the same level of medical education as the experts, and sometimes it can be difficult for a jury to relate to the expert or understand the concerns that he is attempting to explain. An expert must be able to relate to all members of the jury regardless of their level of education, which is sometimes difficult to do.

Dr. Doane: I feel the difference between the plaintiff's counsel and the defense counsel is that the plaintiff's counsel is a little more emotionally tied to the case; due to a potentially large award, for example. The plaintiff's counsel seems to use the emotional element to sway the jury, whereas the defense counsel is just a little bit more standoffish, maybe not as intimately passionate with the jury.

Attorney Ryan: There is no reason why the defense counsel cannot be intimately involved in the proceedings. In fact, there is every reason for the defense counsel to be just as emotional as the plaintiff's attorney. At the end of my closing, if the evidence goes in my favor, I tell the jury that the plaintiff's theory is absurd as presented and that my expert and my client have rejected it. I can paint the scenario that the theme raised against my client is unsub-

stantial, and I emphasize to the jury how offensive that is. I want the jury to understand that it had the opportunity not only to hear my client, but to take the measure of the man, to hear what he said in the witness box, to see what his patients mean to him, and to gauge the level at which he places his standard of care. That is what I want the jury to understand. I am as passionate as I can possibly be under those circumstances. Even if I have to concede that a serious complication has occurred, I can passionately present a defense without casting aspersions on the plaintiff. Rather, I cast those aspersions on the plaintiff's expert or attorney. This can be done in a way that is very compelling. There is no reason in the world for a defense counsel to be standoffish or hands-off. You may have to use the velvet glove when cross-examining the plaintiff, but not when you cross-examine the expert. I do not know why defense attorneys are often seen in that light. There is plenty of room for passion.

Dr. Speaker: I had one experience where the plaintiff's expert was extremely theatrical, even thespian-like. The defense expert was one of the best people in our field, but compared to the plaintiff's expert, he came across as being wishy-washy, simply because he was professional and not theatrical. If I had to pick an expert witness again, I would probably look for someone who could be a little more theatrical. That is not what we are trained to do, but I think it is what is required in the courtroom.

Dr. Slade: I believe one of the most prolific plaintiff's experts in New York is a semiprofessional actor. Is that right?

Dr. Speaker: Yes.

Dr. Trattler: Can more than one defense expert testify at trial?

Attorney Ryan: The court may not allow it. If the testimony from several defense experts is simply duplicative or if the experts have the same specialty and opinion, the court will not allow cumulative testimony. If you can find experts in different specialties, such as someone to testify about the damages and somebody else to testify on the standard of care in connection with the surgical technique, then the court may permit the use of more than one defense expert.

Dr. Coleman: I think there should be a database available online of doctors who serve as defense and plaintiffs' experts, and it should provide an objective measure to

PROTECTING YOUR ASSETS FROM MALPRACTICE CLAIMS

Three mechanisms to prevent malpractice creditors from seizing your assets.

By Gideon Rothschild, Esq, and Daniel S. Rubin, Esq

All signs indicate that the prevalence of litigation against physicians for malpractice is in a continuing upward spiral across the US. Although some malpractice claims are meritorious, far too many are not. In such an atmosphere, even the most skilled and diligent physicians are subject to an unacceptable level of risk. Aggravating this problem for physicians is the fact that even in those instances in which liability for malpractice might be clear, the extent of the injury (and the dollar amount of the damages) often remains subjective and can therefore be grossly inflated by an overzealous judge or jury.

Thankfully, the old adage that to be forewarned is to be forearmed still rings true, at least for those physicians who take heed before the onset of litigation. This article will demonstrate specific steps physicians can take to safeguard assets from future malpractice (and other) claims. Moreover, these steps can supplement and in some instances even replace professional liability insurance. The umbrella term for such steps is often called *asset protection planning*.

TRANSFERS TO OTHERS

One of the most basic techniques used in asset protection planning is simply transferring assets to one's spouse or to (or in trust for) one's children or other family members. Although generally protective, such transfers involve surrendering (1) all rights to control the transferred assets, and (2) any certainty that the transferor can continue to enjoy the benefits of the transferred assets. Transferring assets to one's spouse also subjects the owner to the possibility of losing assets as a result of divorce. Additionally, such transfers (for less-than-adequate consideration) have sometimes been held to be subject to attachment by the transferor's creditors where the transferor earned most or all of the family's income. Using a legal fiction known as a *constructive trust*, the courts have sometimes held that the transferee spouse is merely holding the property as a trustee for the benefit of

the transferor spouse, thus permitting a creditor to attach the transferred assets. Finally, to the extent that the transfer is later deemed a *fraudulent conveyance*, the transfer will be unwound by the courts and the transferred property will be paid over to the transferor's creditors.

Other traditional planning techniques include the use of the homestead exemption, the use of exemptions for life insurance and annuities, and holding property with one's spouse as tenants by the entirety. Each of these techniques, however, is limited in its protectiveness and varies from state to state; the details are beyond the scope of this article.

LIMITED PARTNERSHIPS AND LIMITED LIABILITY COMPANIES

Transferring assets to a limited partnership or limited liability company is another fairly common asset protection technique. Under this technique, the owner of the property contributes it to a limited partnership in which he or she is the general partner, wherein other family members (including the transferor) are named as limited partners. As the general partner, the transferor retains control over the assets in a fiduciary capacity for the benefit of all of the partners. At the same time, the assets are generally secure from the claims of the creditors of any individual partner because the assets are owned by the entity, rather than by the individual partner. Under what is known as the *charging order protection*, a creditor of a limited partner is generally only entitled to attach the interest of the limited partner in the partnership, and thereby receives distributions only if and when distributions are made. Of course, if the general partner of the limited partnership is a family member, he or she is unlikely to make any such distributions until after the debtor partner has successfully settled the creditor's claim, which itself provides the debtor partner with the necessary leverage to do so.

In addition to the asset protection benefits that a limited partnership can provide, it can also prove beneficial for more traditional estate planning purposes such as saving estate and gift taxes. For example, if a parent is the general partner and transfers a limited partner's interest in a limited partnership to his or her children, the value of the transferred interest will likely be entitled to a discount from the

value of the underlying assets of the entity because the transferred interest is (1) noncontrolling and (2) has no public market. Moreover, because the parent, as general partner, retains total management control over the assets held within the entity (albeit in a fiduciary capacity for the benefit of all the partners), the oft-cited fear of a child obtaining access to substantial sums of money immediately upon attaining majority (as would be the case with a Uniform Gifts to Minors Account or a Uniform Transfers to Minors Account), is not an issue.

THE OFFSHORE ASSET PROTECTION TRUST

Where the liability risk warrants additional protection (at additional cost and complexity), and where the physician desires to retain an interest in the property, the partnership technique can be married to an offshore asset protection trust. As implied by its name, such a trust takes advantage of the law of certain select foreign jurisdictions. These jurisdictions have enacted legislation aimed at attracting trust business by protecting the trust fund from creditor claims, even where the person who established the trust is also a beneficiary thereof. The trust must generally be established offshore because the law of most of the US posits that where a person establishes a domestic trust, and is also a beneficiary of that trust, the trust fund is available to that person's creditors to the full extent of his or her beneficial interest. This principle of domestic trust law holds true even where the trust was established at a time when no creditors existed and even if the future potential for such creditors was wholly unforeseeable at that time. Although four states have enacted legislation enabling such creditor protection for self-settled trusts, significant uncertainty remains as to their effectiveness.

Interestingly, the term *offshore trust* is somewhat of a misnomer in this context. Although an asset protection trust must provide that it is to be governed by the law of an offshore jurisdiction in order to receive the benefits of the asset protection trust, the assets of the trust can actually remain in the US. To avoid losing control over the property, the trust can be combined with a limited partnership wherein the physician is the general partner retaining a 1% interest and the trust receives a 99% limited partnership

interest. If the trust only holds a limited partner's interest in the limited partnership, the trustee has no "day-to-day" authority over the transferred assets in any event. Instead, the general partner maintains control over the partnership investments until such time that an actual transfer of the partnership's assets offshore may be warranted due to a more imminent threat.

THE PROBLEM OF FRAUDULENT CONVEYANCES

The transfer of assets in anticipation of a creditor problem might be deemed a fraudulent conveyance under the law of most states. Accordingly, asset protection planning must be sensitive to avoid circumstances in which the transfer of property appears to have occurred with the intent to hinder, delay, or defraud creditors. Certainly, no transfers can be made that would have the effect (after consideration is given to any pending or threatened litigation) of rendering the transferor insolvent. Under all other circumstances, the issue boils down to how little time elapsed between the time of the transfer and the time of the subsequent creditor's claim. It is therefore imperative that asset protection planning is undertaken as far in advance of a potential creditor claim as possible—physicians should ideally structure their affairs for asset protection before the patient who ultimately becomes a plaintiff ever walks through their office door. Given proper planning, asset protection can be an achievable goal.

Gideon Rothschild, Esq., and Daniel S. Rubin, Esq., are partners in the law firm of Moses & Singer LLP in New York City, New York. Mr. Rothschild is the immediate past Chair of the Committee on Asset Protection of the American Bar Association's Real Property Probate and Trust Section. The authors may be reached at (212) 554-7800; grothschild@mosessinger.com and drubin@mosessinger.com.

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determine the qualifications of the expert.

Dr. Slade: This problem is often analogous to a layperson selecting a physician; they have no idea who to pick.

Attorney Ryan: There are services that provide access to transcripts of experts' testimony, whether for the plaintiff or defense, and you can learn the history of somebody's experience in testifying in court. When I am choosing an expert, I do not ignore any suggestions that my client has, but I do not rely on those suggestions entirely. I have to pick somebody with whom I am comfortable and who will be able to engage the jury and make the case in the courtroom.

Dr. Coleman: If an expert testified well, wouldn't the transcript reflect that? Conversely, if an expert has been in a courtroom 12 times, and every time the judgment was rendered for the other side, then clearly he does not testify well.

Attorney Ryan: You have to do your research. You have to know the lawyers involved in the case, you have to find out who has retained them in the past and what experience they have.

Dr. Coleman: Is that a job for the attorney or the doctor?

Attorney Ryan: The attorneys do it.

Dr. Slade: They should do it together.

Attorney Ryan: True, an attorney should not ignore what the client says in that regard.

Dr. Brint: It has been my experience that your insurance carrier will assign an attorney to handle your case. My first lawsuit went very well with the attorney the insurance carrier selected. For my second lawsuit, the same insurance company picked a different attorney, who I believed was not right for the case and did not grasp the issues. I asked the insurance carrier to assign the attorney who handled my first lawsuit, but the carrier denied my request. I did

not understand this decision. It costs approximately \$5,000 to get a case dismissed, depending on how far it goes. The attorney that represented me in my first lawsuit was able to get every one of his cases dismissed. The attorney that represented me in my second lawsuit incurred legal fees of approximately \$20,000 for the insurance company, and the case barely got past the pleading stage. I called my insurance carrier again and asked that it assign the attorney who handled my first lawsuit. The company finally granted my request. I think you have to develop a rapport with your attorney. If you are assigned an attorney who you do not immediately feel is heading in the right direction, you need to get involved and ask your carrier to reassign your case to another attorney.

Dr. Slade: Dr. Salz, how common is it for a defending physician to challenge the attorney that the insurance carrier has assigned to the case?

Dr. Salz: OMIC tries to avoid that. To our advantage, our board is composed exclusively of ophthalmologists who review every claim. If we receive a claim for which none of us has any expertise, we will send it to someone whom we know understands the issue. Then, we suggest to the defendant doctor a couple of possible experts he can use and let him have a role in picking the one he wants. We also have an idea of the good attorneys in particular areas. For example, we have one attorney we work with frequently who sometimes appears to know more

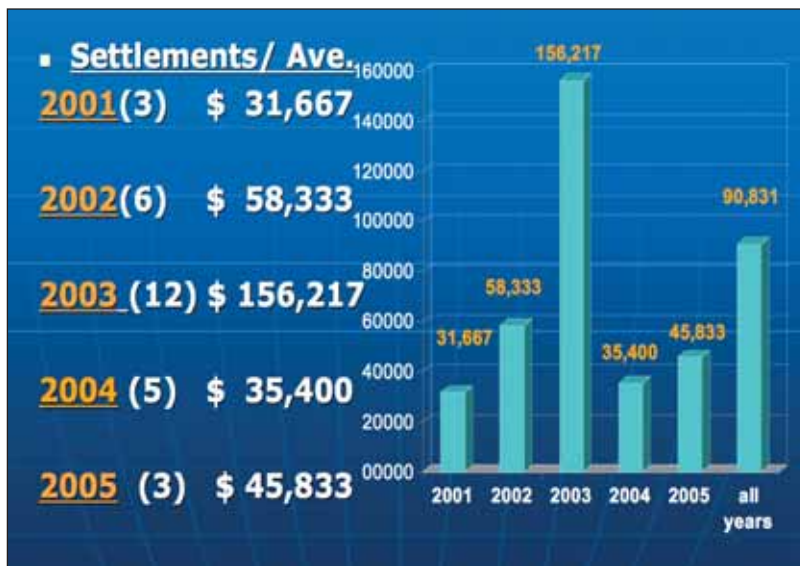


Figure 3. This graph shows OMIC's settlement average for LASIK lawsuits from 2001 through July 1, 2005.

(Courtesy of Ophthalmic Mutual Insurance Company)

about LASIK than some refractive surgeons. He understands most of the issues, and we use him a lot for our defense.

Attorney Krafczek: When physicians are seeking professional malpractice insurance, one of the factors they should research and understand is to what extent they are permitted under their policy to be involved in selecting the attorney to defend them in the event of a lawsuit. Dr. Salz, to what extent does OMIC permit physicians to be involved in selecting their attorneys?

Dr. Salz: If a defendant had an attorney who we investigated and found competent, we would allow that attorney to defend the case. That is unusual, however.

Dr. Slade: Dr. Speaker, do you advise physicians to retain personal counsel in addition to the attorney who the insurance company assigns?

Dr. Speaker: It is not a bad idea to have your personal attorney review your case, at least superficially, along with the attorney assigned to defend you by your insurance company so the assigned attorney understands that somebody is looking over his shoulder. Unfortunately, there are inherent conflicts of interest in the insurance system. Although the attorneys assigned by the insurance companies are representing you, to a large extent, they work for the insurance company.

Attorney Krafczek: Physicians often retain personal counsel in addition to the attorney that the insurance company assigns to defend the lawsuit when there is an issue of excess liability. Attorney Ryan, can you elaborate on the concept of excess liability?

Attorney Ryan: Excess liability is exposure for damages above your primary insurance policy limits. With excess liability, you certainly want to have your own lawyer involved. If you are in a situation where your insurance coverage may not cover the claim, and you think the claim should be settled, and your insurance company is dragging its feet, ask your personal counsel to make your feelings known to the insurance company.

Also, although I certainly understand why people believe that their lawyer is working for the insurance company, we attorneys take our responsibility to the individuals we represent very seriously. When we have to make a recommendation to the insurance company that is inconsistent with the position that the insurance company has

taken up to that point in the litigation, we do not hesitate to make it. Furthermore, we are glad to have personal counsel on board if they want to join in the chorus, but representing a client is something we take very seriously.

Dr. Nordan: The truth is that there are many different qualities of insurance companies. For instance, I dealt with NORCAL Mutual Insurance Company (San Francisco, CA), which is run by physicians. NORCAL would rarely settle a case, and I never felt that the attorney who represented me was serving any other interests, nor did I feel any need for oversight. I had a tremendously good experience with my malpractice carrier. However, I find that big, general insurance companies in which medical malpractice is one of many foci are often too quick to settle cases. These are questions that physicians should ask before picking an insurance company. It is very important these days to find out about the quality and philosophy of an insurance company before you sign with it.

Attorney Ryan: Some companies will not pay for certain experts who they deem too expensive.

Dr. Nordan: My insurance company lets me pick any attorney in the country, and allows the attorney to do everything my personal attorney could do and more. NORCAL retains the best attorneys. It never skimps on defending a claim, because it refuses to settle. That is its reputation.

STANDARD OF CARE

Dr. Slade: Are ophthalmic standards of care evolving due to recent litigation? Dr. Donnenfeld, please comment on the committee that you, Dr. Salz, and Perry Binder, MD, created and secured backing for from the AAO and ASCRS. This committee presented some recommendations for ectasia, which is one of the most common foci of lawsuits. Do you think your recommendations will have an effect on current standards of care?

Dr. Donnenfeld: In response to a large verdict in New York, the ASCRS, AAO, and ISRS got together a few years ago and brought together a team of experts in the area of LASIK and ectasia. This committee created a white paper¹ on what was known about ectasia, and I think it has established a standard for the current knowledge about ectasia. I believe it was very helpful. However, although our committee published this information on the behalf of ophthalmology and ectasia lawsuits, it is subject to scrutiny by plaintiff's attorneys as well.

Nevertheless, one of the most helpful ideas on which the committee is working now is bringing other ophthalmologists into this group in an effort to become a clearinghouse for ectasia cases. We are considering evaluating ectasia malpractice cases and responding to them in a sensible way. We would seek multiple opinions on whether there was negligence or malpractice, and we would be willing to serve as experts for the plaintiff and for the defense in cases we think are defensible.

Dr. Doane: Dr. Donnenfeld, was the white paper a standard for understanding the situation, a standard of care, or a clinical practice pattern for ectasia?

Dr. Donnenfeld: We tried to identify what we currently know are the risk factors for ectasia. We established that what we know now is not what we knew 5 years ago, and that the standard of care is evolving. We also tried to create a list of practices we think are the current standards of care for evaluating patients for LASIK to reduce the risk of ectasia. If surgeons follow the standard of care that we outlined in this paper, they will be on higher ground if they find themselves in a lawsuit.

Dr. Nordan: I thought that the white paper was confusing. It seemed to conclude that ectasia is multifactorial and therefore surgeons should take their best shot. It was a nice attempt, but I do not think it lends very much to the standard of care. As for the idea of being a clearinghouse for expert witnesses who will testify for defense and plaintiffs, I think it is a conflict of interest alongside establishing a standard of care. Surgeons have to get their own specialists, and they should use those who worked on that white paper, but I do not think you should tie legal expertise to standard-of-care work. Those are two different processes, and I do not think they belong together.

Dr. Slade: I have one comment before Dr. Donnenfeld responds. Dr. Nordan said that he thought the paper was confusing. Ectasia can be a confusing subject. I thought the paper went a long way toward revealing what we do not know about ectasia. There is no science on it. We have no longitudinal study following patients with elevated floats or high K readings.

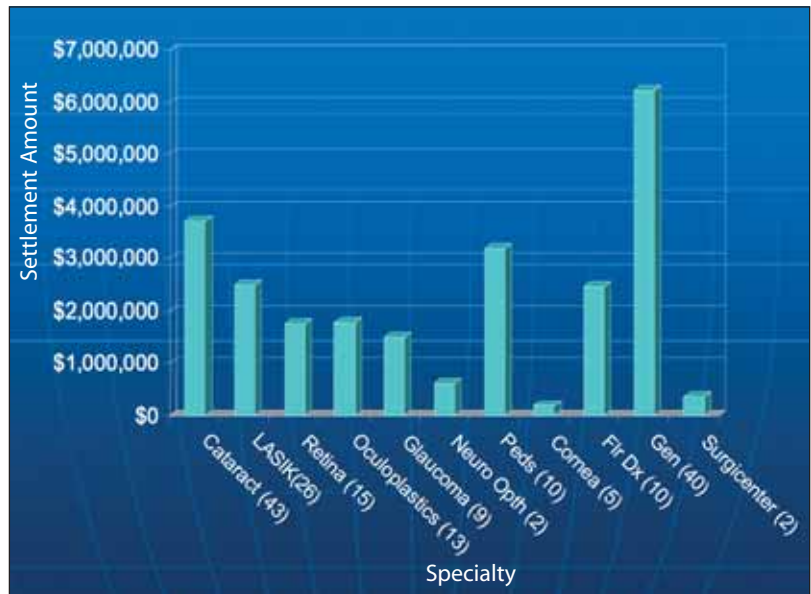


Figure 4. This graph shows OMIC's total settlement amounts per specialty between 2001 and 2004.

(Courtesy of Ophthalmic Mutual Insurance Company)

Dr. Coleman: There are so many different aspects to ectasia. I am not sure whether any specific study shows that thinner-than-average corneas alone put patients at a high risk for ectasia in the absence of an abnormal topography.

Dr. Nordan: The expert's opinion will assist with that determination.

Dr. Donnenfeld: The committee had so many divergent opinions that what we put in the white paper were markers upon which we could all agree. Foremost, we agreed that there was no magic bullet for screening for ectasia.

Dr. Slade: I think that determination is the value of the paper.

Dr. Nordan: But that determination does not help a surgeon's defense in court.

Dr. Donnenfeld: The white paper basically says that patients who develop ectasia may have a perfect preoperative examination. You can perform a beautiful LASIK procedure on a patient who is a perfectly good candidate for surgery and end up with a bad result. That is the strongest statement in the paper that should be presented at trial.

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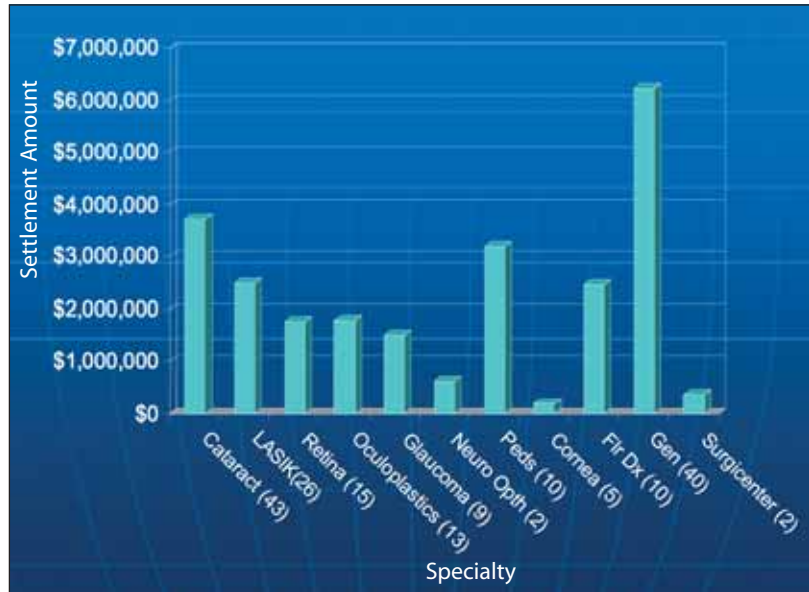


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dence in his surgeon. Comanagement sometimes makes patient/surgeon interaction difficult, because patients do not see their surgeon at every clinical visit. As for when to settle a case, I think it ultimately boils down to whether or not you are willing to risk a jury trial. In my case, the plaintiff and the judge did not believe that it was a strong case, so the plaintiff demanded \$1,000,000 to settle. My defense thought it had a defensible claim, so we rejected the demand to settle.

Dr. Slade: Would you have done anything differently during the course of that lawsuit, prior to going to trial?

Dr. Speaker: In retrospect, I am not sure that we could have done anything differently at the time. Going forward, I am more persistent about maintaining contact with my patients.

Dr. Donnenfeld: In my case, I kept good contact with the patient. My staff and I were intimately involved in following the patient for several years and had a great rapport with her. I do not think I could have done anything differently in that respect. On the witness stand, the patient did not say one bad word about me; in fact, she said I was a wonderful doctor, which I think upset the jury and helped her case. She did not have a problem with me, she was just unhappy with her result. She did not try to make me look like a villain. Also, I was very happy with my expert, as I have said.

Dr. Potter: My one tip to avoid litigation is to understand as best we can how significant vision loss of almost any manner is to our patients. In my experience, this is one way the physician-patient relationship is damaged and can become irreparable, which is a problem for both the doctor who wants to help the patient, and the patient who needs his doctor now more than ever. My colleagues and I within TLC Laser Eye Centers and outside the organization have studied this problem and believe we have found some ideas that can assist the doctor to help the patient.

Many dissatisfied patients go through typical grieving behavior, and most optometrists and ophthalmologists do not have an awareness or understanding of that

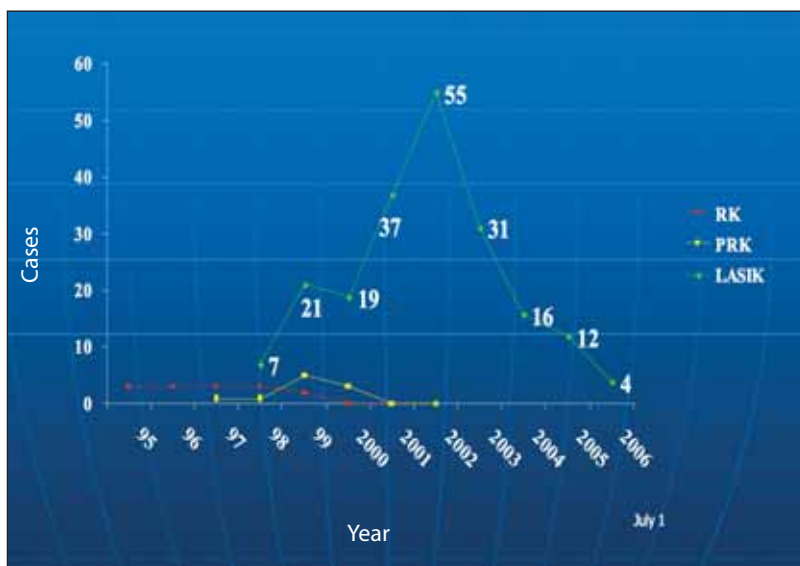


Figure 5. This chart shows OMIC's frequency of LASIK malpractice claims by date reported between 1995 and July 1, 2006.

(Courtesy of Ophthalmic Mutual Insurance Company)

behavior or how to respond. When we respond appropriately and match the patient's stage of grieving, we are able to settle our differences professionally without the threat of litigation. I wrote an article on this topic that was published in *Primary Care Optometry News* last year entitled, "Help Refractive Surgery Patients Cope With Unexpected Results."² I know that all surgeons have at some time tried as hard as they could to help an unhappy patient, who in turn was trying to express how much he was suffering, but instead the two grew farther apart on the issue because there was no common ground between them. The doctor does not understand the patient, and the patient cannot imagine why the doctor cannot understand how much he is suffering.

Dr. Salz: Attorneys like to settle a case when we think it is indefensible. By the same token, if we think the doctor has done nothing wrong, we find no issues with his standard of care, and we are confident in our expert's testimony, then we want to defend the case. OMIC wins four out of five of the lawsuits that go to trial, which is a standard rate among other insurance companies.

INFORMED CONSENT

Attorney Krafczek: Can the panel please comment on the role informed consent played in your respective malpractice matters?

Dr. Nordan: With an essentially refractive practice, I

would point out that informed consent is a process; it is not a document. The document gives a false sense of security. Quite often, your staff can negate a valid informed consent process. For example, the nurse may say to a patient, "This complication really never happens, but sign the paper anyway." I urge all surgeons to be involved to some degree in the informed consent process and not to delegate it 100% to a nurse. Let the patient know directly that complications do occur. The single greatest deterrent to lawsuits I have found is including a statement in the informed consent that the patient must write out in longhand that says, "I understand the potential risks and benefits of these surgeries." Many surgeons hesitate to ask the patient to write out such a statement because they think the patient will be scared away from surgery. You cannot scare him away, and it will be more difficult for a jury to believe that a patient did not understand the statement if he wrote it in longhand.

Dr. Donnenfeld: In my case, the plaintiff acknowledged that I talked to her about the risks and benefits of the procedure, but that other people had discussed them with her as well, and it should have been done only by me. The informed consent should only be given by the physician and not by an optometrist or ancillary personnel.

Dr. Slade: I want to emphasize one point about sitting down with the patient, something I do with every patient before surgery. I learned this lesson thoroughly with myopic keratomileusis. I sit down with the patient and review the informed consent, and I write out their comments. When Dr. Nordan would come to Houston, I would see him doing this. He sat with the patient and wrote in longhand that he discussed various items. I document that I asked the patient if he had any further questions and if he understood the informed consent.

Dr. Trattler: I think the key is to identify every abnormality, large or small, that makes your patient less than an ideal surgical candidate. You should document these issues in the patient's medical record and provide informed consent as to how these issues could potentially impact his surgical outcomes. You should document, for example, when there is a small abnormality in the topography that may increase a patient's risk for ectasia as well as identify patients with large pupils, which can result in an increased risk of night vision complaints, etc. Once the patient has been provided informed consent and elects to undergo surgery, he cannot later complain that the surgeon failed to identify and discuss an issue prior to sur-

gery. This is important, as the general informed consent that a patient signs is not specific to every patient. Dr. Salz uses an informed consent with a checklist that includes almost every surgical issue that can occur.

Dr. Doane: One of the greatest lessons I have learned is never to give up on the patient. The second you walk away, you are lost. Also, in this digital age, it is important to talk with the patient. I invite my patients' family members to talk with me. Then, I e-mail them a review of what we discussed, and I carbon copy myself for a record to put in their chart. Even if a patient has a poor outcome, I think it is important to let him know that I am on his side. The second you lose contact with the patient, you do not know what will happen.

Dr. Brint: One of the biggest challenges I have faced was whether to settle a major lawsuit I was involved in several years ago. It was a case of ectasia that occurred in 1999 and went to trial in 2002, and virtually every expert I talked to said they would have operated on the patient. I failed to argue that the standard of care I knew in 1999 was below what I practiced in 2002. I think that had I not applied the standard of care in 2002 to a case from 1999, I could have defended it, and I should not have settled. Once you start the settlement process, you do not know what the amount will ultimately be. In my case, it was a lot, more than what it might have been had I gone to court. In hindsight, I wish I had gone to trial and that I had brought in the experts who would have supported my standard of care in 1999.

Dr. Salz: To underscore what Dr. Nordan said, I think that getting the patient to write his understanding of the informed consent is wonderful. All surgeons should put a signed and dated note in the patient's chart that they personally discussed the risks of complications with the patient. If a case should come to trial, the jury should find such information to be credible and acceptably thorough. If you have no record of having that discussion with the patients, then the jury may have a more difficult time accepting your testimony.

Dr. Slade: It seems that the ideal outcome would be to win as opposed to settle. To those of you who experienced a trial, was it worth it to win?

Dr. Coleman: I felt as though I dodged a bullet, but I did not feel good. The patient still had ectasia. I spent several weeks not sleeping, being difficult around my family, and

canceling patients, so I did not feel like a winner at the end of my suit.

Dr. Slade: Dr. Speaker and Dr. Donnenfeld, if you had had the choice in your lawsuits between winning and settling for a certain amount of money, would you have gone through with the trial, or would there have been a settlement value you would have accepted? What would have been the best outcome for you?

Dr. Donnenfeld: There is no winner, one way or the other; it is a very stressful and destructive experience. However, if every malpractice case settled, insurance rates would triple, or our insurance companies would stop our coverage.

We have a moral obligation to defend these cases, especially high-profile ones. If we do not, the number of malpractice cases will increase exponentially. Plaintiffs' lawyers often do not wish to go to trial. They want to settle cases. When you are faced with a malpractice case, you must ask yourself, "What is my coverage? If I settle, the insurance pays everything. If I do not settle, is there the possibility that I will have any out-of-pocket exposure?" These issues are hard to quantify, but if I could do my case over again (and I am in the process now of appealing it), I would make the same choices, 100%. I know I did not commit malpractice, and I would never agree to any type of settlement. If I go to court and I win, I will feel good about it.

Dr. Coleman: To Dr. Donnenfeld's point about malpractice insurance rates increasing if physicians start settling: the fact of the matter is, most cases do settle. Very few actually enter a courtroom. So, the scenario you are describing is the current state.

Dr. Donnenfeld: A lot of cases do get settled, and a lot of cases that are filed are frivolous. I sincerely think that more lawsuits would be filed if people knew they were going to get money with a settlement.

Dr. Salz: The number of lawsuits being filed is diminishing. I agree that it is a mistake to settle high-profile ectasia cases that are defensible, where the doctor clearly acted within the standard of care and all the patient's

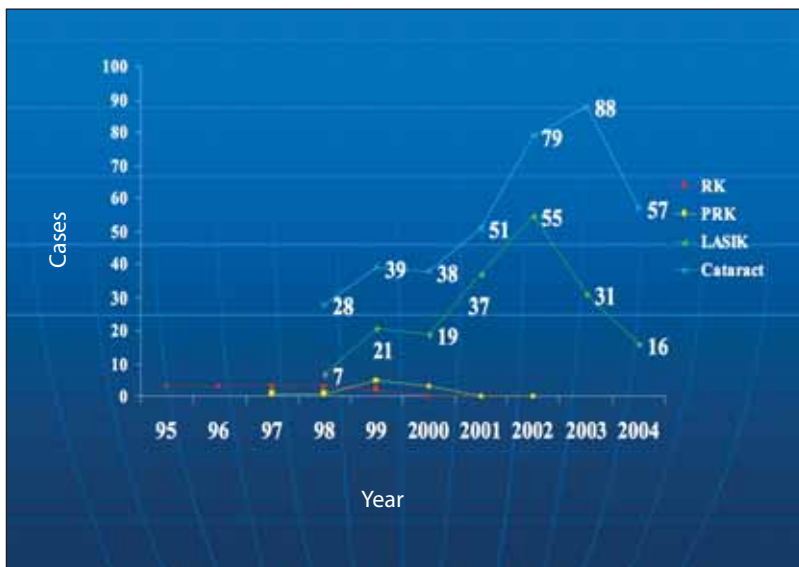


Figure 6. This chart illustrates OMIC's LASIK malpractice claims by date reported from 1995 through December 31, 2004.

(Courtesy of Ophthalmic Mutual Insurance Company.)

preoperative calculations made sense. Settling such lawsuits fuels a frenzy among the plaintiff's attorneys. They think any ectasia case is going to be worth \$1 million or more, and we have to litigate and win these cases to reverse that trend.

Dr. Slade: What do our attorneys think about these comments?

Attorney Ryan: I do not think ophthalmology can have a policy of capitulation, although I know that is not what Dr. Coleman is advocating. I think these cases must be tried. Is there an OMIC policy that requires your consent before settlement?

Dr. Salz: Yes, and OMIC also has something called the *Hammer clause*, which we have only used once. This clause allows us to encourage someone to settle a lawsuit, or else they will be liable for the damages if they refuse to settle and lose. For example, if we do not think we can defend a case and a defendant refuses to settle, OMIC will cover the cost of the trial, but if the plaintiff wins, then the defending doctor must cover some of the costs. The insured is liable for any indemnity payment above the amount OMIC would have settled for and all the costs accruing after the date that we could have settled.

Dr. Trattler: My malpractice carrier has the ability to settle lawsuits without the doctor's consent as well. We

have our own self-insurance trust of approximately 125 doctors in South Florida. This insurance trust runs like a business, and if its administrators calculate that it is less expensive and less risky to settle a case than to go to trial, then they can settle a case. The main positive is that the rates for the self-insurance trust are well below the “market” rates, and in fact, the rates have gone down each of the last 4 years.

This issue affected me in 2006, when I was involved in the only medicolegal case of my career. It was a retina case. The patient experienced elevated eye pressure from the expansile gas that was placed in the eye at the time of retinal detachment surgery. The retina surgeon identified the elevated IOP on postoperative day 1 and worked to keep the pressure at a more normal range. While the retina specialist was out of town for a few days, a doctor in my group and I monitored and treated the patient’s eye pressure on a daily basis, which included Christmas day. The patient developed some peripheral vision loss and decided to initiate a lawsuit. Interestingly, the retina specialist had such a good relationship with the patient that he was not named in the suit. The insurance company settled the lawsuit prior to trial without asking for the defendants’ consent, because the defense team was concerned that the jury could find some negligence with the retina specialist and/or the hospital.

Attorney Krafczek: Clearly, the answer is not to settle every case. You have to carefully evaluate the specific facts and circumstances of each and every case in deciding whether to litigate or settle. Every lawsuit has its own unique set of facts and circumstances. Among the issues you should consider when deciding whether to litigate or settle are: Why is the plaintiff filing this lawsuit? What is the basis for his claims? Are these claims supported by the evidence? How strong is your defense to these claims? Is there any documentation to support your defense, and if so, how compelling is it? How much in monetary damages is the plaintiff seeking to recover? What are the limits of your malpractice insurance policy, and can there be any excess liability exposure? How much is your malpractice carrier willing to contribute toward a settlement? How much is it worth to you, the physician, to have this case go away today as opposed to enduring possibly years of litigation, and you should carefully take into account the physical, emotional and financial burden the litigation process will have on you, your family, and your practice. Typically, there is no clear-cut right or wrong answer in each case. You have to carefully consider these as well as many other issues in each particular case, and the defense

attorney needs to advise his client based on all these circumstances. At this point, you can then make an informed decision about whether to proceed with litigating or settling your case.

Attorney Ryan: Attorneys are seeing more people turning toward alternative dispute resolutions such as mediations, arbitrations, and high/low agreements. A *high/low agreement* is a contract between the parties to set parameters on any potential award. Under a typical agreement, a guaranteed amount (the “low”) is paid to the plaintiff if the trial or arbitration results in a defense verdict. If the case results in a verdict in favor of the plaintiff and against the defendant, the defendant pays the amount awarded unless the amount exceeds the upper parameter (the “high”), in which case the defendant’s liability is limited to the “high.” Especially in self-insured operations, there is a move toward preemptive intervention. This occurs when a patient suffers a significant complication and the attorney for the practice or physician meets with the patient or the patient’s family immediately in an attempt to resolve things fairly. This alternative has worked effectively in the Philadelphia area.

Dr. Speaker: At TLC, in addition to informed consent, patients are now required to sign a waiver foregoing litigation; they must use arbitration rather than go to court. If the patient will not sign that waiver, I do not operate on him. Every patient of mine has signed. Have the courts ruled on whether that type of arbitration provision is binding?

Dr. Potter: We currently have claims that involve the issue of the arbitration provision, but we do not have any decisions on those matters as of yet. We still have more to learn about how states view arbitration and how best to use it to help the patient and support the doctors.

Attorney Ryan: Mandatory arbitration has not been upheld in all states. In many states, in fact, it is a difficult hill to climb. This type of provision may serve to deter some plaintiff’s attorneys who may be on the fence about bringing a lawsuit, but in my experience, it has not been the ultimate deterrent. Using arbitration as a resolution mechanism among the parties has been very useful, especially in situations where there is the potential for a verdict in excess of the defendant’s insurance coverage. Arbitration has the added benefit that, if arranged correctly, any settlement made to the plaintiff is not reportable to the databank.

Dr. Potter: Your points are well taken. I think arbitration and other forms of dispute resolution and conflict management represent how hard we in the industry are trying to resolve malpractice issues before they end up in a courtroom.

WHAT ARE SOME OF THE LEADING COMPLICATIONS THAT RESULT IN MALPRACTICE SUITS TODAY?

Dr. Slade: What complications are causing lawsuits to be filed these days, and is there anything that causes concern for future litigation?

Dr. Salz: Table 1 represents all OMIC LASIK trials, a total of seven. We received defense verdicts in four of the seven cases. One case resulted in a \$2,200 award to a plaintiff who suffered a decentered ablation. The two remaining cases on this table show more substantial awards for the plaintiffs. One involved keratectasia and a probably unrecognized thick flap, the case in Texas we discussed earlier.

The final suit was a killer. We thought it was defensible, because it involved a loss of suction. During discovery, a video of the procedure showed the surgeon applying the keratome to the patient's first eye, dilating the pupil, achieving good suction, and making the flap. On the second eye, the surgeon did not achieve good suction, and the pupil did not dilate. The plaintiff's expert, who was a LASIK surgeon, testified that the surgeon should never have attempted to make the flap under those circumstances. The videotape was a very compelling piece of evidence.

Dr. Slade: To summarize these lawsuits, they involved a technique question, a topography, two postoperative complications (diffuse lamellar keratitis and a wrinkled flap), a decentration and abnormal healing, and a surgical complication (decentered ablation). Given the nature of these complications, what do you worry about the most today in your practices, and what do you see as the major areas of concern?

Dr. Speaker: I think the primary concern is selecting the right procedure for the patient. We still do not have very good data about what the real risk factors for ectasia are.

Dr. Slade: Do you think you will identify a different primary factor in the future?

TABLE 1. RECENT LASIK TRIALS AND THEIR VERDICTS

3/6/00	RK Post op progressive hyperopic shift	Defense verdict	
11/27/01	LASIK – decentered	Plaintiff Verdict	\$2,200
5/8/02	LASIK – Wrinkled flap	Defense verdict	
6/2/03	PRK - decentration & abnormal healing	Defense verdict	
12/01/03	LASIK – mild DLK post op	Defense verdict	
6/19/06	LASIK – topography suspect Keratoconus? (Surgeon performed less than 100 procedures)	Plaintiff Verdict	\$944,000
6/26/06	LASIK - Loss of suction Pupil not dilated when suction ring applied	Plaintiff Verdict	\$275,000
6/27/06	PTK double vision	Defense Verdict	

(Courtesy of Ophthalmic Mutual Insurance Company)

Dr. Speaker: I hope so, as we get more information and better technology.

Dr. Donnenfeld: I think the number-one concern is ectasia, and that it will be so for years to come.

Dr. Slade: Failure to diagnose and failure to comply with the standard of care for the diagnosis of ectasia?

Dr. Donnenfeld: Yes, because ectasia has nothing to do with a failure to diagnose. In refractive surgery, we follow up with a complication as indicated. We will most likely lose a lawsuit if the patient ends up needing a corneal transplant, at least in New York. New York juries will perceive a corneal transplant as malpractice regardless of what the evidence shows at the time of trial. You have to make certain the patient is aware of the risks. To that end, surgeons will use a lot more PRK than in the past, because that procedure reduces the risk of ectasia in most people's minds.

Going forward, the issue of dry eye following LASIK and PRK will also become significant. You must carefully document that you evaluated the ocular surface and took proper precautions to reduce the risk of dry eye postsurgically. I also think we will see fewer issues of pupillary size and glare going forward, because they have been pretty well documented.

Dr. Slade: John Marshall, MD, recently stated that he thinks a thin flap made with an Intralase FS laser (Intralase

Corp., Irvine, CA) has virtually identical strength and biomechanical characteristics to and perhaps is even stronger than PRK.³ Will you therefore use more LASIK or more thin-flap LASIK superficial punctate keratitis in the future?

Dr. Donnenfeld: I have switched to using thin flaps in all of my LASIK cases. For an eye with a true topographic abnormality, I would do PRK, because that procedure is perceived as being safer in those cases. There will always be experts willing to testify that PRK is safer than LASIK.

Dr. Slade: Dr. Potter, what do you and your colleagues at TLC worry about the most in terms of getting sued, and do you think it will change in the future?

Dr. Potter: First, I agree with Drs. Speaker and Donnenfeld that ectasia and dry eye problems are still the gravest issues for ophthalmologists. We have seen a new development in the past 12 months, however, that we are keeping an eye on. We have received some long-term disability claims and have been asked to respond and document the patient's vision loss. We may see more disability claims in the future than litigation.

Dr. Brint: I agree that we will continue to worry about ectasia and dry eye, although the dry eye issue may be waning with surgeons' heightened awareness.

Dr. Trattler: Ectasia is obviously a major issue facing us in the next couple of years, but another area of concern for refractive surgeons is going to be the melding of cataract and refractive surgery. A small percentage of refractive IOL patients are going to develop severe vision loss due to endophthalmitis or retinal detachment. More commonly, quality-of-vision issues could arise in a subset of multifocal IOL patients. Surgeons getting involved in presbyopia-correcting IOL surgery should be aware of these issues and need to be able to troubleshoot patients' complaints.

The preoperative screening of refractive IOL patients is also critical. Practitioners are discussing the necessity of performing topography on all refractive IOL patients to identify topographic abnormalities preoperatively. I also perform an optical coherence tomography scan preoperatively to check the macular health of all our presbyopia-correcting IOL patients, because we may identify retinal abnormalities. For instance, a patient with an epiretinal membrane preoperatively can have a very unsatisfactory result with a multifocal IOL. I think the refractive IOL arena can potentially have a lot of risk.

Dr. Brint: I treated a patient who was an attorney. Initially, he sent me a demand letter but decided not to pursue the case and did not file a complaint. I had planned to implant an Acrysof Restor IOL (Alcon Laboratories, Inc., Fort Worth, TX) but had broken the capsule. This was before the three-piece Restor was available. The patient sued me because I implanted a monofocal IOL instead (I had no other option). After the surgery, I informed the patient that I was unable to give him the lens he wanted, but that I expected to be able to do an IOL exchange in the future for the Restor IOL. As a result, the attorney sent me the demand letter. My point is that Dr. Trattler is right; we have not begun to see the tip of the iceberg of what may happen with the refractive IOLs.

Dr. Coleman: I agree that the hot button for cornea-based procedures is ectasia. I think the white paper went a long way in trying to describe to lay people (meaning, a jury) the overwhelming likelihood of a corneal transplant's being successful. I think we as a profession have done a very poor job of highlighting our success with corneal transplantation, particularly now with the femtosecond laser's ability to create corneal buttons. That success rate will continue to increase, but I also think we have to educate the public that a corneal transplant does not equal blindness.

Dr. Slade: I could not agree with you more. Dr. Salz, what are your thoughts on current and future concerns for surgeons?

Dr. Salz: Because we are better able to identify abnormal topographies, it is important to realize that LASIK is not always the ideal procedure and we can substitute PRK. However, we must document in the informed consent that we discussed this option with the patient. Seven years ago, I identified an abnormality (inferior steepening) on topography in one eye of a 30-year-old patient. I told the patient he could not undergo LASIK and that, even with PRK, his abnormality could progress to keratectasia, as it might without surgery. He asked to proceed with PRK, and 7 years later, that eye developed keratectasia. I implanted Intacs (Addition Technology Inc., Des Plaines, IL), and he now wears a hybrid contact lens to achieve 20/20 vision. I recorded all of our discussions in his chart, and we had a good relationship without the threat of a lawsuit. He knew the risk he was taking by undergoing surgery.

Corneal transplants will continue to improve and will cease drawing the amount of damages that would otherwise entice an attorney to pursue a claim. Thus, potential

damages are likely to be substantially less for a complication that we can fix compared to those for a patient who suffers blindness.

Dr. Slade: Is it OK to perform PRK on a patient with forme fruste keratoconus and/or keratoconus with proper informed consent?

Dr. Trattler: With proper informed consent, I think the answer is yes. Some well-performed studies have shown that for at least the first 5 to 10 years, the corneas in these patients remain relatively stable. Personally, I evaluate each case based on the severity of the forme fruste keratoconus and how much tissue I would have to remove. I think thin-flap LASIK treatments may work well on these eyes, but

RECENT LEGAL CONCERNS IN REGARD TO OPHTHALMOLOGY

By Randall J. Olson, MD, and Anthony P. DeMichele, Esq

We ophthalmologists were given an incredible gift when the Centers for Medicare & Medicaid Services' (CMS) ruling removed the issue of not being able to balance bill for presbyopia-correcting, new-technology IOLs. Sufficient payment should encourage the development of a multitude of new lenses that will dramatically improve the quality of treatments for refractive surgery patients, in particular the treatment of presbyopia. Our actions in this new arena are currently under the microscope, however, so we must be careful about our charges for presbyopia-correcting IOLs.

BALANCE BILLING AND THE CMS' RULING

Balance billing occurs when a beneficiary is asked to pay the difference between the actual charge for a covered service and the amount that the health coverage provider has contractually agreed to accept as full payment for the covered service. Balance billing does not include the collection of copayments and deductibles. The practice of balance billing may result in providers breaching their agreements with third-party payors. There may also be violations of state insurance and consumer protection laws.

The CMS' ruling changed the way presbyopia-correcting, new-technology IOLs may be billed. The agency's rulings act as precedent to final opinions and orders as well as statements of policy and interpretation. The rulings shed light on ambiguous regulations and laws associated with Medicare, Medicaid, and private health insurances. The specific ruling that changed the way that ophthalmologists may bill for presbyopia-correcting IOLs was issued on May 3, 2005, and authored by Mark B. McClellan, the administrator for the CMS. The ruling concluded that additional services that are intended to correct presby-

opia are not considered covered services. Physicians may therefore bill and collect for these additional services without this practice being considered balance billing.

FAIR CHARGES

With flexibility in our billing practices, we still must ensure that our charges are fair and reasonable, and we must be able to document how our fees were determined. The Office of Inspector General (OIG) is responsible for protecting the integrity of the Department of Health and Human Services' programs as well as the health and welfare of the beneficiaries of those programs. The OIG performs this function through audits, investigations, and inspections, and it has made clear that it will investigate in particular those who appear to be abusing the privilege. Our ability to bill for additional services must represent real costs, including the actual time spent (eg, educating patients, surgery, follow-up) on these new IOL technologies.

Not only should we conduct a careful review of all costs in association with presbyopia-correcting lenses, but the actual expenses should be audited and the charges adjusted accordingly to show a good-faith effort to meet the conditions of our agreement with the CMS. Simply choosing a number without any documentation could open an individual to potential penalties—and jeopardize the privilege given to ophthalmology.

ANTITRUST VIOLATIONS

Because we now may bill Medicare patients for the additional services associated with presbyopia-correcting IOLs, we must be exceedingly watchful for antitrust violations related in any way to price fixing. The problem could be as simple as several independent groups casually discussing prices and agreeing on

the patient must understand that his risk of developing ectasia is much higher than an average patient's. Informed consent is, of course, critical.

Dr. Slade: If I had keratoconus and were considering having a graft, I would certainly opt for PRK or thin-flap LASIK, because I do not think those procedures would

compromise my outcomes with a graft. Dr. Donnenfeld, what are your thoughts?

Dr. Donnenfeld: I presented a paper at the 2006 AAO annual meeting on my experience with performing PRK on patients with mild forme fruste keratoconus.⁴ My patients had excellent results, although, if a surgeon operates on

a general rate or one group calling another to discuss their costs and agreeing to adjust them so that there is not a cost differential. Antitrust violations are not to be taken lightly. The penalties are potentially devastating, and, in these situations, triple damages are often imposed of whatever the difference might be from the competitive cost in regard to seemingly innocent collusion.

THE STARK ACT AND ANTI-KICKBACK STATUTE

Violations of the Stark Act and Anti-kickback Statute are actively investigated. Pursuant to the Stark Act, an ophthalmologist is prohibited from referring a Medicare patient for certain designated health services to an entity with which the ophthalmologist has a financial relationship, unless the ophthalmologist satisfies one of the safe harbor provisions contained in the Act. Under the Anti-kickback Statute, individuals and entities are subject to criminal penalties if they knowingly and willfully offer, pay, solicit, or receive bribes, kickbacks, or other benefits in an effort to induce the generation of business that is reimbursed by Medicare or other federal healthcare programs.

There are multiple safe harbors clearly spelled out in regard to comanagement. If not carefully worked out, however, some cases of comanagement in which the surgeon clearly could easily handle the postoperative care can create cause for investigation and penalties and, therefore, deserve careful scrutiny. If there is any question whatsoever, legal review is recommended, because the penalty can be severe, even including jail time.

Bundling is another area of concern in regard to the Anti-kickback Statute. Bundling occurs when an entity provides an item or service for free or for a fee that is less than the fair market value in order to induce the purchase of another item or service. Because a package price is often given in ophthalmology, even a sense of a gift or inducement to buy a product for a

decreased cost in other areas (ie, the cost of phaco equipment is added for free) can be considered a violation of the Anti-kickback Statute. A loss of licensure can occur, depending upon the severity of the claim. This problem could pertain to presbyopia-correcting IOLs if the ophthalmologist purchases a lens with bundling that might represent a significant discount on his purchase of equipment or other items. If not extremely carefully constructed, such bundling could result in an investigation and penalties with all of the concerns associated with the Anti-kickback Statute.

CONCLUSION

The OIG is clearly looking at a few specific issues in relation to presbyopia-correcting IOLs. Although ophthalmologists generally lack a legal background, we still need to recognize when we are on thin ice. If there is even a hint of concern, we should obtain legal advice. Following a sound legal opinion is an important defense should our practices ever be investigated.

Anthony P. DeMichele, Esq, is an associate with the law firm of O'Brien & Ryan, LLP, in Plymouth Meeting, Pennsylvania. Mr. DeMichele's practice involves commercial litigation, healthcare law, professional liability, and nursing home and long-term care litigation. He has represented physicians and healthcare practitioners in disciplinary board actions and in employment-related matters. Mr. DeMichele may be reached at (610) 834-6235; ademichele@obrlaw.com.



Randall J. Olson, MD, is John A. Moran Presidential Professor and Chair of Ophthalmology and Visual Sciences at the University of Utah School of Medicine in Salt Lake City. Dr. Olson may be reached at (801) 581-2352; randall.olson@hsc.utah.edu.



enough eyes, eventually some of the patients will go on to develop ectasia. The question is whether keratoconic patients will develop ectasia if they do not undergo PRK. The entire issue revolves around informed consent. I agree 100% with Dr. Salz that it is imperative to inform the patient that you recognize the presence of an abnormality and therefore an increased risk of surgical complications. The patient must be willing to accept the increased risk and to document his acceptance. Again, the issue is not whether the patient will develop ectasia, because someone eventually will. The question is whether you make him aware of the possibility of this complication. As ophthalmologists, we need to do a very good job of informed consent. We have to outline the specific risks for every patient. When a patient becomes a surgical candidate, he should have a boilerplate informed consent. If there is anything abnormal about his eyes, whether large pupils, high myopia, high astigmatism, dry eye, etc., you have to indicate and document that you recognize the problem(s) before you operate.

Dr. Slade: I would urge every ophthalmologist to make sure that his informed consent spells out the fact that he cannot always diagnose keratoconus and that it is a surgical risk. Significant suspicious signs and symptoms must be specifically discussed with the patient and documented as such. Now, I have a comment sheet that reviews every risk specific to the individual patient, and I sign the sheet as I discuss each issue with him, but I do not have the patient sign it. Dr. Salz, do you think my signing this sheet is enough legally, or should I also ask the patient to sign? Should that be part of my informed consent or just part of the patient's chart records?

Dr. Salz: I think it is fine to keep the sheet as part of the chart record. I do not follow Dr. Nordan's practice of having patients handwrite part of the informed consent, although doing so would be indisputable in court. The point is to inform patients of the common generic complications of surgery (usually adequately covered by the written informed consent) and then also to discuss specific risk factors such as large scotopic pupils, borderline abnormal topography, or dry eye that might potentially increase their risk of an unfavorable outcome. This discussion of unique risk factors should then be documented with a note in the record.

Attorney Ryan: I agree with that. I see a lot of malpractice lawsuits in which these things are not documented or where physicians have to rely on their standard of practice. That is a much tougher sell in court. I have seen cases of some doctors asking their patients to write on the progress

notes in their hospital chart. Documentation is always best.

PATIENT SELECTION

Dr. Slade: Let's talk about patient selection. Please give your insights on the patients to avoid and then any closing comments you may have.

Dr. Coleman: I think the most damaging effect a lawsuit can have on the practitioner is to make him jaded so that he starts to look at every patient in terms of their likelihood to sue. Historically, I have been a poor judge of who may be quick to sue. I do not think there is any reliable way to consistently predict litigiousness based on personality.

Dr. Slade: Dr. Trattler, what type of patient worries you?

Dr. Trattler: I enjoy treating challenging patients, such as those who have undergone previous surgery with another surgeon and are unhappy with their outcome. I do not worry that they may be litigious. I really try to focus on how I can help my patients and impact them positively. There is no specific patient type that I try to avoid.

Dr. Brint: I agree. I do not think you can predict the patient.

Dr. Slade: Dr. Salz, what sets off your red lights?

Dr. Salz: In our practice, my colleagues and I perform wavefront analysis on every patient, and I love sitting with them and showing them that all eyes have aberrations. With today's technologies, we are not likely to make these aberrations much worse, although sometimes we do negatively impact a patient's quality of vision. By discussing the unpredictability of surgery ahead of time, I think patients get the feeling that, although refractive surgery today is better than ever, they may not get the results they want.

Dr. Slade: I think Dr. Coleman is right in that you want to be careful about not putting yourself in an adversarial position with your patients. Try not to start viewing every patient as a potential lawsuit, because you will lose sight of the fun you can have in this profession. Practicing medicine gives you the opportunity to meet 40 or 50 people a day, and you may find somebody you like.

Dr. Donnenfeld: Despite all the hassles of these medicolegal issues, I think ophthalmology is an extraordinary

profession, and I will continue to enjoy it. I think the take-away message here is for surgeons to document everything they do and have an extraordinarily good informed consent. We must specifically indicate any ocular abnormalities our patients have and make them aware. I also think it is a good idea to have the patients document in their charts in their own handwriting that they have been made aware of all the risks of surgery. If we take these steps in addition to performing skilled surgery, then I think we will be in good shape legally.

Dr. Slade: How would you fix the problems of medical malpractice lawsuits in 20 words or fewer?

Dr. Donnenfeld: I would have a physician board that reviews cases. I also think the plaintiff's attorneys should be responsible for the costs associated with the litigation if they lose a medical malpractice lawsuit.

Dr. Doane: I think a review board of say, three ophthalmologists would be helpful. I believe that it would be in the best interest of all parties—ophthalmologists, plaintiff's attorneys, and other interested parties—to have some input on how these board members are selected.

Dr. Slade: Dr. Salz, tell us what you would do to change the current legal system.

Dr. Salz: I never answered the question about what I would do differently in a lawsuit, so I will touch on that quickly. In my lawsuit, I missed the technician's incorrect axis input into the laser system and doubled the patient's astigmatism, creating mixed astigmatism. The next day, I immediately told the patient what had happened. I did not have the ability to fix the error with a laser, so I made two arcuate incisions, corrected her to 20/25, and performed LASIK on the patient's second eye for free. Both her eyes ended up nearly 20/20. Afterward, she said, "Dr. Salz, I think I'm still entitled to something else." And I said, "What do you mean? I've done the surgery for you. I am sorry about the mistake, but your vision is fine." She said, "Yes, but I was miserable, I had headaches, and my eyes were different." I did not want this event to go to court, because it was a deviation from the standard of care to input the wrong axis. The insurance carrier offered her a settlement of \$5,000. She did not think that was enough, so she filed a lawsuit anyway, and she ended up with a settlement of \$30,000. Thinking the experience through again, I think if the carrier had offered her around \$10,000, she might have accepted without hiring an attorney. As far as improving

the system, I think Dr. Donnenfeld hit it right on the head. If we had a physician panel that included ophthalmologists to review these cases before they were filed, we could act on their advice and avoid costly trials, and everyone would benefit.

Dr. Brint: Florida had the rule where a person could not file a lawsuit unless he already had an expert's opinion to support his claim. It is pretty easy to get an expert to offer an opinion in support of your claim, however. Louisiana has a peer review committee that includes three ophthalmologists, and they are able to eliminate probably two-thirds of potential claims. Plaintiffs perceive that we ophthalmologists band together to protect ourselves, so they are wary of this process, but it still helps. At the end of the peer review process, which typically takes about 30 to 90 minutes, both attorneys enter the room with three doctors: one appointed by the plaintiff; one appointed by the defendant; and the third chosen by the first two physicians. In the worst-case scenario, they say that malpractice occurred and that the physician should settle at that point. If they say unanimously there is no evidence of malpractice, which is what happens 95% of the time, they can educate the plaintiff's attorney about why. It is a good educational process for the plaintiff's attorney. I think the idea should be used more widely.

Dr. Slade: Something we did not discuss is what do you do if you start sensing that things are going wrong with the patient? Should you just say, "Sorry you are unsatisfied. Here is your money back"? A lot of times, people will threaten a physician in order to get their money back.

Dr. Trattler: If they want their money back, consider having them sign a waiver.

Dr. Slade: What is OMIC's policy on that, Dr. Salz?

Dr. Salz: I think OMIC would discourage a refund unless it was very clearly written out that the patient was going to accept it and would not pursue a lawsuit. Without such an agreement, the patient could accept the refund and still sue.

Dr. Slade: So, any form of settlement should be a part of a release of liability settlement?

Dr. Salz: Any type of offer for a discount or refund could be construed as an admission of wrongdoing. Oftentimes, however, a troublesome case does not reach that point. If you are sympathetic to the patient's complaints, manage the complication effectively, and address

the patient's needs at that point, you can often avoid a lawsuit. If the patient wants you to re-treat him for free or refund his money, and you agree to either course, make sure you get him to sign a valid release. I would even recommend that the patient be represented by counsel during the signing. If the patient does not have an attorney review the release before he signs it, then he could argue that he did not understand what he was signing.

Attorney Krafczek: In that situation, I would recommend that both parties consult with and be represented by counsel. The physician should have his attorney prepare the release and require that the patient be represented by counsel when he signs it. Otherwise, the patient could subsequently argue that the release is invalid.

Dr. Slade: Dr. Trattler, closing comments?

Dr. Trattler: A couple of things. First, Florida passed a state constitutional amendment called the "three strikes and you're out" rule. It mandates that physicians who lose three malpractice cases by a jury trial lose their licenses.

Dr. Salz: What about three settlements?

Dr. Trattler: Settlements do not count. Interestingly, I think the rule states that there must be three jury trial losses in a 5-year period, so there may be a lot of malpractice settlements in Florida to avoid going to court, especially by physicians who have already lost one court case. The different legalities of each state are an interesting topic.

Second, I would recommend to any physician who gets sued to not take it personally. The plaintiff and his attorney often see a jackpot at the end of a lawsuit. Discrediting you is not their main goal.

Dr. Slade: It is about the money.

Dr. Trattler: The legal system is an arena in which the physician does not have much control. In my lawsuit, for example, I knew that I had not done anything wrong and had provided the patient with appropriate care. I think it is helpful to understand the system that is in place.

Finally, all malpractice lawsuits hinge on the plaintiff's expert. We need to reel in these experts. Ophthalmology needs a database of physicians who have testified in clinical cases so we can look at their testimonies. We could then see who is giving proper testimony and who fabri-

cates things, and make that knowledge public. If experts' testimonies are published, then their credibility is either reinforced or ruined among their peers. Accountability is important in the legal arena. I also think there should be a way to make sure these experts are practicing in the clinic what they preach in the courtroom. There are a number of attorneys who have a medical license and may be former ophthalmologists who now serve as plaintiff's experts, but they no longer practice ophthalmology. I think that a certain amount of an expert's income should be from ophthalmology in order for him to be allowed to serve as an expert witness.

Dr. Slade: Experts should perform the surgery they are testifying about in the technical way they support, and their approach should be widely accepted.

Dr. Coleman: It amazes me that experts will defend patients whom they have never examined. An ophthalmologist would never perform surgery on a patient without first meeting and examining him. I would think it would be important for the expert witness to get a sense of the person who is pursuing the litigation. Fortunately, I believe that the topics we have discussed here today hit an inflection point, or peaked, in 1999. Cases performed in 1999 went to trial in 2001, 2002, 2003, and we are clearly on the down side. In my practice, this is reflected by the list of patients whom I am truly concerned about postoperatively. These are people who perhaps have a flap that was a little bit decentered or that shifted or someone who has a refractive outcome that was not quite expected. Maybe someone's 1-year topography looks a little bit funny. This list has gotten shorter and shorter, and I have not needed to follow up as closely with as many patients as I used to. So, clearly, I think we are coming out of this tailspin with respect to patients and potential litigation.

Dr. Slade: Thank you all for contributing to this informative discussion. ♦

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Anatomy of a Lawsuit II: Closing Thoughts

Mark Speaker, MD, PhD, shares his experiences on trial.

BY STEPHEN G. SLADE, MD; ADAM KRAFCZEK, JD; AND SARA E. SMITH, MANAGING EDITOR

The staff and editorial board of *Cataract & Refractive Surgery Today* received an overwhelmingly positive response from ophthalmologists and industry for the "Anatomy of a Lawsuit II" issue that was published in October 2005. This feature article presented an in-depth look at the \$7.25 million verdict in the matter of *Mark Schiffer vs. Mark G. Speaker, MD, et al* (available at <http://www.crstoday.com/PDF%20Articles/1005/1005CurrentIssue.html>). But what about the personal side to this ongoing story, the impact to the surgeon? Readers deserve to know what Mark Speaker, MD, the defendant, has to say about his thoughts during and after the trial.

We are most thankful to Mark for his help. He has been more than generous with his time throughout this process and was again willing to answer some difficult questions, including what helped during the trial, what hurt the outcome, and how his practice is faring.

Why was he willing to do this interview with CRSToday? Mark knows we are all at risk to face what he did. I believe he is trying to give his colleagues direction in the event that one of us finds himself in a similar situation.

—Stephen G. Slade, MD

Dr. Slade: What did you learn from the trial that you would like to share with your colleagues?

Dr. Speaker: As surgeons, we expect some patients to have undesirable postoperative outcomes, despite our best efforts. After practicing corneal and refractive surgery for 18 years at a level I thought was among the highest in our profession, I believed that I would have the confidence in my patient in the event of a bad out-

"For the plaintiff and the attorney, it is all about the money. I think there are a lot of better ways to compensate deserving patients."

—Mark Speaker, MD, PhD

come, but I now believe that way of thinking is pretty naïve.

Dr. Slade: What is the lesson? Never assume that your patients are going to stick with you?

Dr. Speaker: I did not initially understand the financial temptation that is dangled before an unhappy patient and the potential plaintiff's attorney such as that by the New York State legal system, which permits a lay jury that has no technical knowledge to offer unlimited financial awards for medical lawsuits. For the plaintiff and the attorney, it is all about the money. I think there are a lot of better ways to compensate deserving patients.

Dr. Slade: How did your colleagues treat you? Were they supportive?

Dr. Speaker: Many of my colleagues called or e-mailed me from all over the country and around the world with their support.

Dr. Slade: Was there anything in the trial process that surprised you or that you did not understand?

Dr. Speaker: I did not understand what a profound influence the judge could have in precluding or allowing evidence that would significantly influence the opinion of the jury. I also did not understand to what extent the plaintiff's attorney and an expert witness could go to turn the gray areas in medicine into absolute black and white, and where the truth could become exaggerated and/or distorted.

I also did not understand how the objectives of my insurer, which is Medical Liability Mutual Insurance Company (New York, NY), could be different from my own and significantly affect the outcome for me.

Dr. Slade: How were they different than yours?

Dr. Speaker: At the end of the trial, when the jury asked to review the economic data again, which was introduced into evidence during the trial by the plaintiff regarding his claimed damages, my attorney said this was an indication that we may lose the case, and that the jury was trying to determine how much to award the plaintiff. My attorney asked me if I wanted to settle at that point, and I said yes. My insurance company said no, that we should take the verdict. My insurance company's exposure was limited to my policy limits, so it was going to be the same for them no matter what.

Dr. Slade: What other decisions were not in your favor?

Dr. Speaker: There were many decisions throughout the trial that were not in my favor, some of which were more significant than others. For example, despite the fact that the plaintiff left his banking career after 1 year with no mention to his employer or colleagues of any vision problems as the reason for his leaving, the judge denied my attorney access to the plaintiff's psychiatric records. These could have shed some light on whether his vision was truly the reason for his leaving his employment.

Additionally, the plaintiff was terminated from a previous investment banking position at another firm for making misrepresentations on his job application. On the job application he neglected to report he had been arrested earlier in his life. Nonetheless, the judge stated that we could not refer to this information because it would be too prejudicial.

The judge also denied my attorney's request that I be admitted as an expert witness. According to the judge, it is her practice not to admit a defendant as an expert witness in his/her own case. I believe this ruling had an impact on the jury and their opinion of me.

Finally, for the jury's review, the judge allowed into evidence a 1999 editorial by Douglas Koch, MD, entitled "The Riddle of Iatrogenic Keratectasia."² According to my attorney, this is contrary to New York State procedural law, which prevents literature from being entered into evidence because it allows the plaintiff in essence an expert witness who cannot be cross-examined. The plaintiff's attorney used this editorial to criticize my decision to perform LASIK. The editorial was requested by the jury during their deliberations, and in my opinion undoubtedly influenced their decision.

Dr. Slade: What did you think of the jury?

Dr. Speaker: It was certainly not a jury of my peers. None of them had any medical background or any means to evaluate what was being presented. The central issues in the case were what was the standard of care in 2000 and interpretation of topography.

Dr. Slade: In this case, did your insurance company select your attorney for you?

Dr. Speaker: My insurance company appointed my attorney. I checked him out and he had an excellent reputation as a senior partner at one of the largest medical malpractice defense firms in the city. I did not have any input in this selection.

Dr. Slade: What would you have done differently in preparing for this trial?

Dr. Speaker: I feel I was underprepared. I did not understand how the legal system in medical malpractice cases worked. In New York State, the plaintiff's attorney is not required to tell us who their expert witness is until he takes the stand. The New York State trial process also allows the plaintiff and their experts to go through any relevant literature and ask you if such and such a source is authoritative. If you say yes, then they can challenge you with everything that is in that source as if you authored it yourself. The plaintiff's attorney went through past literature on topography and keratoconus, most of which is irrelevant to today's practice.

Dr. Slade: How did you deal with your practice throughout the trial?

Dr. Speaker: Well, everybody else in my practice was working except for me, but I was able to schedule some surgery during the trial. When the jury came back with a verdict, I was in the OR performing a corneal transplant on a one-eyed attorney. How is that for irony?

Dr. Slade: In your opinion, what were the more controversial positions the plaintiff's expert testified to in the trial?

Dr. Speaker: This trial was a platform for Amoils to testify about his views on PRK versus LASIK, his Amoils brush which he developed, and how he helped to setup the Surgical Eyes Web site. He practices in South Africa, never practiced in the US or New York State, notwithstanding that the law says that the expert witness has to testify to the standard of care in the community. Amoils testified that there was a global standard of care, but then later testified that there was in fact no global standard of care. I do not believe he had any credentials to testify about the standard of care in our community. He had no knowledge of Krachmer, Mannis, and Holland's textbook,³ which was the best-selling textbook on cornea at that period of time, and had never heard of the AAO's home study course for Board Certification.

Dr. Slade: What kind of interaction did you have with him, if any, during the trial?

Dr. Speaker: Amoils was very content with himself. He spent a considerable amount of time describing all of his contributions including a cryoprobe for retinopexy. During cross-examination, he testified that the cryoprobe was still used in every retinal detachment surgery performed today. When we challenged him in the mid-1980s that endophotocoagulation replaced cryo because of the association of proliferating vitreoretinopathy with cryo, he denied that this was true.

Dr. Slade: Is he known as a plaintiff's expert?

Dr. Speaker: He claims that this is the first time he testified in the US, but according to the doctors in South Africa, he has testified in their country. He has no academic appointments.

Dr. Slade: What other testimony did Amoils give?

Dr. Speaker: One of the major inaccuracies in his testimony that was given repeatedly was that inferior steepening on placido topography is indicative of a bulging of the cornea. Elevation topography can do this. Amoils was intent on convincing the jury that an inferior steepening on topography was diagnostic of corneal ectasia or keratoconus, despite documentation that the patient had a normal cornea on examination, above-average pachymetry, normal retinoscopic reflex, and normal BCVA.

Amoils also testified that the standard of care in 2000 was not to perform LASIK on a low myope with 590- μ m pachymetry and inferior steepening on topography, and that this standard of care was established by one case report from Theo Seiler in 1998.⁴ Amoils' claim was that one case report changed the standard of care and made inferior steepening a contraindication. He spent a long time testifying about his own paper, a series of case reports of ectasia with incomplete information that was published in 2000.⁵ Amoils would not admit that the first scientific study of risk factors for ectasia was published in 2003 by Randleman et al;⁶ 3 years after the plaintiff had his surgery. These deficiencies are important details that are totally lost on a lay jury.

Amoils also testified that the standard of care in 2000 was to obtain an Orbscan (Bausch & Lomb, Rochester, NY) preoperatively on a patient with inferior steepening. The latest ASCRS survey shows that this is still not the case because less than 40% of refractive surgeons used an Orbscan in 2004.⁷

Another important inaccuracy in Amoils' testimony was that the postoperative Orbscan of the patient's unaffected dominant right eye showed that the patient would develop ectasia and need a corneal transplant. Ed Holland testified that this Orbscan was normal.

Dr. Slade: What about your expert, Ed Holland?

Dr. Speaker: I think Ed did a great job. I would not criticize anything that he said. He testified that he would have operated on this patient and that the preoperative topography was not a contraindication.

Dr. Slade: What would you do over?

Dr. Speaker: The one thing that I think maybe I could have been done better would be how I handled the questions concerning which literature is authoritative.

Dr. Slade: This involved your testimony about the literature?

Dr. Speaker: Yes, Amoils and the plaintiff's counsel were going through all of the old literature on keratoconus trying to prove that the plaintiff had keratoconus preoperatively, and that we should have known that because of the old literature from the days of radial keratotomy surgery. Because of the plaintiff's attorney's ability to limit our answers to "yes or no," it was not possible for us to explain to the jury why that literature was not being used correctly to support their argument. This gave the jury the impression that we were being evasive.

Dr. Slade: Did you get to know which papers they were going to show you ahead of time?

Dr. Speaker: No.

Dr. Slade: But some of the papers were not authoritative and you said so, and the jury did not like that?

Dr. Speaker: Correct. The major focus of Amoils' testimony was Rabinowitz's and McDonnell's work on topographic indices for keratoconus.⁸ My attorney showed Amoils the conclusion by Rabinowitz about the importance of the clinical examination in the diagnosis of keratoconus, which in this case was entirely normal. The one definitive conclusion in Rabinowitz's paper is that clinical examination is the gold standard for diagnosis, and Amoils did not agree with this.

Dr. Slade: When the jury finally left the courtroom at the end of the trial to start the deliberation process, how long were they out?

Dr. Speaker: A day and a half.

Dr. Slade: What was your lawyer telling you at that point; was it a good sign or a bad sign that the jury was out for a day and a half?

Dr. Speaker: The only bad sign was that they asked to review the economic data introduced at trial by the plaintiff's damages experts regarding what they claimed his damages were.

Dr. Slade: Was the plaintiff ready to settle?

Dr. Speaker: Prior to the trial, the plaintiff offered to settle for my insurance limits, which was \$2.3 million, but I said no because I thought my care of the patient

was appropriate. After Holland's testimony, the judge suggested a \$1.0 million settlement and I said no because I thought Amoils' testimony was weak, and my expert witness, Ed Holland, was terrific. My lawyer thought we had a 95% chance of winning the case at this point. Clearly, the jury had a different opinion than the plaintiff.

Dr. Slade: What about the settlement after the verdict?

Dr. Speaker: The verdict occurred at the end of July. From then until the day in September when the post-trial motions were scheduled to be heard before the judge, the plaintiff showed no interest in settling and repeatedly made mention of their expectation that I would personally contribute to a settlement. I said no, because I was advised that we had a strong case on appeal.

"The one thing that I think maybe could have been done better would be how I handled the questions concerning which literature is authoritative."

—Mark G. Speaker, MD, PhD

Dr. Slade: You do not have to pay the amount of the verdict until after the appeal is decided, correct?

Dr. Speaker: You have to post a bond in order to appeal. However, the day the trial judge was scheduled to hear our post-trial motions where we were asking for either a new trial or a reduction of the verdict because it was excessive and not supported by evidence at trial, the plaintiff's lawyer called my lawyer and expressed a desire to settle for my insurance limit of \$2.3 million. I think they did this because they knew that they had a weak case on appeal. They apparently decided to take the money and run.

Dr. Slade: Would you settle if you had to do it all over again?

Dr. Speaker: Yes, I would settle within my insurance limits in this case because of the outrageous judgment. It was the best thing to do for my family, my practice,

for me. I had dealt enough with the legal system and lawyers.

Dr. Slade: How has this affected your practice? Is your volume up or down? Are patients supportive, or do they not know about it?

Dr. Speaker: I have had a lot of patients express support. There have been some patients who have asked questions about it, but seem to understand how this came about. I am not aware that I have lost any patients because of it. A lot of my patients are bankers and lawyers, they are used to this.

Dr. Slade: Has this case affected your self-confidence?

Dr. Speaker: No. I treated this patient appropriately based on the information available in 2000, as confirmed by Ed Holland.

Dr. Slade: How has this affected the way you treat patients?

Dr. Speaker: It has not affected the way I treat patients, but it has caused me to be more scrupulous in documentation. During my testimony at trial, the plaintiff's counsel made an issue that I did not document my preoperative examination of the patient. I testified that my routine was that if there had already been an examination on the chart that I did not document mine unless there was something remarkable. The plaintiff's lawyer asked me, "have you ever heard the expression 'if it is not documented, it wasn't done?'"

Dr. Slade: Has it changed your surgery mix? Are you doing more PRK and less LASIK?

Dr. Speaker: No. During the last couple of years my colleagues and I have been doing more PRK. At this time, 10% to 15% of my laser surgery is PRK.

Dr. Slade: Has this affected your ability to obtain malpractice insurance? Are they still covering you or have they raised your rate?

Dr. Speaker: It is a doctor-owned company and they have been very supportive.

Dr. Slade: Are you going to raise your malpractice limits now?

Dr. Speaker: I don't think I can.

Dr. Slade: Do you think that refractive surgeons should have high, low, or medium malpractice limits?

Dr. Speaker: I think my case is probably instructive in that regard, because here was a runaway verdict for \$7.25 million, which ended up settling within my insurance limits. Also, the plaintiff had to consider running the risk of losing the entire case on appeal, or, as an alternative, seeing their verdict drastically reduced.

Dr. Slade: What general advice would you give colleagues facing a medical malpractice suit?

Dr. Speaker: Assume that you know nothing about the legal system. Ask a lot more questions of your attorney and insurance company than I did. I would also recommend that if you have to go to trial that you should have a personal attorney advising you. It may also be worthwhile to have a private investigator check out plaintiffs who are making exaggerated claims. I did not do that, but probably should have. ♦

Stephen G. Slade, MD, is in private practice in Houston. Dr. Slade may be reached at (713) 626-5544; sgs@vision-texas.com.

Mark Speaker, MD, PhD, is owner of Laser & Corneal Associates, PC, in New York City, and is Medical Director at the Manhattan TLC Laser Eye Centers. Dr. Speaker may be reached at (212) 832-2020; lasikspeaker@aol.com.

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