Managing Errors in Treatment in Refractive Surgery

It is a complicated subject to address but one that cannot be ignored.

BY JOHN POTTER, OD

In refractive surgery, managing errors in treatment and how they affect patients is difficult. Your patients, however, will certainly expect you to discuss the various aspects of the situation with them.

The goal of any strategy for managing errors in treatment is to help the patient. Although this objective seems obvious, it is far harder to achieve than it may seem at first. An error in treatment suggests that someone made a mistake, usually one that harms the patient. As a result, the doctor/patient relationship is damaged, and medical malpractice claims may occur. The mishap is an emotional and difficult experience for all involved.

Although many kinds of errors can occur in refractive surgery, I will address the ones that I see most frequently and offer advice on handling them.

WRONG PATIENT/WRONG PROCEDURE

It is possible to treat the wrong patient or to treat the right patient with an incorrect refractive calculation. Frequently, the resulting refractive error is quite great, so it is obvious that the outcome of the surgery is not very good. Unfortunately, some refractive surgeons still do not disclose such errors to the patient. In my and my colleagues' experience, the complete admission of a mistake is the right thing to do for patients. We have worked diligently to develop a system of disclosure that provides patients with the information they need, not just the details the surgeon wishes to share. An essential concept is that it is not what you say that matters; what the patient hears and needs to hear are most important.

Conventional wisdom in refractive surgery is to wait 6 to 12 months for the cornea to heal before considering an additional procedure. During this time, the patient can wear a contact lens or depend upon his better-seeing eye. In my experience, this scenario rarely plays out the way the surgeon thinks it will. Few patients with significant ametropia in one eye can achieve satisfactory vision with a contact lens. Most are unable to wear the lens for more than 1 or 2 months. In addition, patients usually must try several lenses before they achieve the kind of vision and comfort they require. Finally, each time they remove the contact lens from their eye, they are reminded that the surgeon made a mistake.

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Performing additional refractive surgery after the initial problematic procedure instead of waiting requires a lot of gumption in my opinion because not only is the patient in shock, but so are the operating surgeon and the entire staff.

You may obtain a patient's informed consent while he is in shock, especially if the compliance materials are delivered in a meaningful and sincere manner, the surgeon has expressed regret about the surgical error, and a family member or a loved one is present to support the patient. In contrast, a patient may claim he consented to an additional procedure when he was unable to understand his options. In my experience however the former is more likely to happen as long as complete disclosure of the treatment error has occurred and the surgeon offered a sincere expression of remorse.

REPEATED ERRORS

Sometimes, surgeons make a mistake twice. The problem is most likely to occur during the initial period of shock over

the error if the surgeon proceeds with a retreatment. For example, one may repeat an astigmatic error because of the 90° symmetry of astigmatism. To mitigate the risk of a second error in treatment, I recommend asking a colleague who was not involved in the original surgery to review the treatment plan.

MISSED TARGET

Some patients who desire monovision undergo another treatment instead. For example, the surgeon may correct both eyes for distance.

Even after excellent surgery, there may be problems with near vision. A presbyopic patient who elects to have both eyes corrected for distance may complain on postoperative day 1 that he has poor intermediate and near vision. The surgeon calmly reminds the patient of his preoperative discussion and informed consent, but, sometimes, a patient is inconsolable. A 10-minute visit turns into an hour of tribulation.

Time and again, patients in these circumstances demand immediate additional treatment, or they request a refund because the procedure did not meet their expectations. Patients' options are limited. In my experience, they rarely opt for a monovision retreatment in the future, even if the surgeon refunds the fee paid for the original surgery. They frequently express great concern to the surgeon that the retreatment procedure will not achieve the desired outcome, either. Even if their reaction seems out of proportion relative to the remedy (ie, wearing spectacles for near and intermediate vision), I can attest that patients' feelings are genuine in these situations.

In general, surgeons are in an awkward position of deciding whether to offer a refund or whether to wait to see how the patient wants to proceed in the future. More often that not, I find that a refund is the best alternative.

PERCEIVED ERRORS

Sometimes, patients are convinced a mistake occurred during surgery when it did not. I find that this is the most difficult type of "error" in treatment to manage. Comments inadvertently made in the laser suite, a ringing cell phone, and other circumstances can cause a patient to believe that he is a victim of an error in treatment. I use the word *victim* deliberately. The anger and resentment the operating surgeon and/or staff may encounter is, at times, remarkable. The doctor/patient relationship is diminished, seemingly irrevocably.

In my experience, claims of medical malpractice following a perceived error in treatment are uncommon. Nonetheless, a patient who believes he was harmed when the facts suggest otherwise is a conundrum. Individuals who are candidates for an enhancement will emphatically refuse to have additional surgery. Nearly all of the patients in cases of perceived error fear that their vision will deteriorate in the future because of the harm they think they sustained. They may view a refund of surgical costs as an attempt to buy them off rather than a legitimate gesture of regret from the doctor. Moreover, they may interpret a referral to another doctor as abandonment.

Even when these patients see another doctor of their own choosing, they nearly always suspect collusion on the doctors' part. The refractive surgeon providing a second opinion often feels overwhelmed by the patient's emotion and fear, which makes the establishment of a meaningful doctor/patient relationship difficult. Oftentimes, the patient thinks the second doctor is misrepresenting what occurred originally. Alternatively, he may think something the second doctor says reaffirms his worst fears and concerns about the initial surgery.

The operating surgeon and patient are at odds for months with no resolution. What can be done? I believe that the best approach is to express regret clearly and concisely as soon as the issue of a perceived error in treatment surfaces. Surgeons should never waiver in how they express regret or in the order in which they outline exactly what happened and did not happen to the patient. Otherwise, the patient may pounce on the differences as supporting his fear that he has been mistreated and that the extent of his injury was not disclosed. The best tool for helping patients in this situation is difficult to find: patience. You may feel you have expressed regret so many times that you cannot imagine that you need to do it again, but you do—in a thoughtful manner and in a proper sequence. It can take months for a perceived error in treatment to reach its logical and eventual conclusion. Even then, it is hard to be certain that the issue has been resolved to the patient's satisfaction.

CONCLUSION

Errors in treatment are difficult for patients and doctors. Obviously, refractive surgeons should do all they can to prevent the occurrence of such problems. When they do occur, however, ophthalmologists will need to strive to resolve the issues. Patients expect nothing less than complete disclosure and a sincere attempt to help them through a complicated situation. ■

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