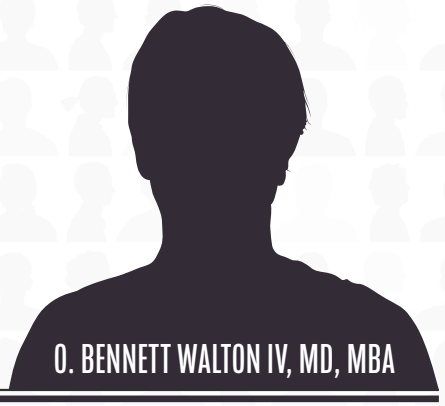
There Is No Single-Use Reputation



O. BENNETT WALTON IV, MD, MBA

In our interactions with patients and medical and regulatory boards, we must give other physicians the benefit of the doubt.

A respected ophthalmologist relayed to me his experience performing cataract surgery on a patient with terminal cancer who had 6 months left to live. An anonymous complaint to the surgeon's state medical board had prompted an investigation into this surgeon for performing unnecessary surgery. The surgeon was forced to forgo income from working while he defended himself against this claim. The patient felt so strongly that she spent one of her remaining days of life traveling with him to the state medical board so she could testify that, yes, she had wanted to see her grandchild clearly before she died and was grateful to the surgeon.

Another ophthalmologist told me he was reported to his state medical board by an anonymous source who claimed that he was making incorrect claims in his marketing. The board opened an investigation, and the ophthalmologist felt the need to hire an attorney and forgo practice income while he traveled to visit the board to defend himself. It was an easy defense to the board because he was able to demonstrate clearly that his objective claim was true. What happened to the anonymous reporter? We cannot know, but most likely nothing. The ophthalmologist was apparently told by the board (paraphrasing), "Well, you know how it is. We have to investigate these things once they're reported."

AS EASY AS AN EMAIL

With something as easy as an email, someone can cause thousands of dollars of lost income and threaten not only the reputation but also the livelihood of a physician through threats to licensure. Further, there are typically no adverse results for accusers, who are often anonymous, even when the physician is found blameless.

Whistleblower protections exist in the corporate legal realm because corporations can be so large and financially powerful that individuals could be coerced, intimidated, or financially ruined by corporate legal fees in the event a corporation successfully defends itself. The imbalance of a big, powerful corporation does not exist with individual physicians, however. Sure, there are large practices, but we practice as individuals who have invested a minimum of 12 years of postsecondary education and training to specialize as we do.

Physicians forced to defend a complaint should be given the courtesy of knowing the identity of the people who accuse them. Complaints against physicians to board authorities should be balanced with the possibility of counter-investigation or penalties for inappropriate attempts to damage a reputation. Protecting the public includes not only investigating impaired physicians but also safeguarding access to the vast majority of honorable physicians.

Most physicians would not know where to start to bring a libel or defamation suit to protect themselves, and most would not want to do so. Without widespread counterbalances to accusations, however, such a suit is sometimes the only option.

THREE PRINCIPLES

Let us step back for a second and consider that the examples I gave at the outset may have been brought about by well-meaning individuals concerned for public safety. Whenever I am asked to comment on another doctor's work or decision-making, there are three key principles that I try to keep in mind.

First, I was not a part of the preoperative conversation in question. When I was a resident, I had a discussion with a refractive surgeon in private practice. In a misguided, judgmental attempt to prove my desire to do no harm, I made a critical statement about another surgeon from outside my home institution who had performed what I had considered an excessively high myopic laser ablation. This mentor told me he had probably operated on several patients

A LEGAL PERSPECTIVE

By Alan E. Reider, JD, MPH

Sadly, the concerns that Dr. Walton presents in his article reflect several problems that are inherent in our system of discipline. Most states allow complaints to be filed anonymously in an effort to encourage physicians to alert medical boards of problems with physicians who truly deserve to be sanctioned. But, as Dr. Walton notes, the cover of anonymity may allow some physicians to misuse this process and recklessly file a complaint without knowing all the facts, or, worse, in effort to cause trouble for a competitor.

Attorneys are frequently asked if anything can be done when a physician is wrongly accused. Most states provide protection for whistleblowers; however, that protection is not always absolute. Rather, it is usually qualified and applies only as long as the physician filed the complaint in good faith. If it can be shown that the complaint was not filed in good faith, that protection would not apply.

The practical reality, however, is that demonstrating that someone did not act in good faith is a difficult burden to meet. Nevertheless, depending on the level of protection provided by the state law, there may be recourse if it can be shown that the complaint was filed in bad faith. At a minimum, the board should be willing to take action against the physician who filed the complaint in bad faith, as that would clearly be an abuse of the process.

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of a similar description over the past decade. Some of these patients are his most grateful, he said, because other surgeons had refused or declined to perform their laser vision correction. He rightfully corrected my judgmental attitude.

His advice has resonated with me in the years since that conversation: All surgeons should make wise decisions for their patients, and risk-avoidance at the expense of everything else is not good care.

All surgeons have their own boundaries for what they deem acceptable recommendations to patients. It is difficult—and perhaps inappropriate—to fully dissociate these patient interactions from our own experiences and personal risk tolerances. I have declined to operate on patients who would clearly benefit from a procedure because my interactions with them led me to believe that they were not emotionally or psychologically equipped to handle accepting risk. I wish I had declined more often, because some of my most frustrating moments have involved patients with clear indications for surgery and excellent visual and surgical results, yet tremendous postoperative dissatisfaction. The key indicator with these problem patients was mistrust toward me and mistreatment of our staff.

Other times, I have proceeded with an intervention that others might deem to have an unacceptable risk-benefit ratio. Some of these patients are indeed grateful to find someone who will make an attempt. In these cases, trust, discussion, and education are vital. If I have not been present when another doctor has participated in these kinds of involved, personalized preoperative discussions, then my retrospective opinion is limited.

Second, in the event of another surgeon's complication, I was not present during the surgery. One of the most important pieces of advice for young ophthalmologists who are preparing for second eye surgery, after a first eye complication by another surgeon this: Assume that there is something difficult about that patient's eyes, rather than assuming a mistake by the first surgeon. Further, since our surgeries depend heavily on patient cooperation and stillness, not having been in the room at the time of a complication limits the full knowledge of any retrospective critic.

Third, new techniques and technologies can seem strange at first. Some of what used to be taboo and vilified has now become mainstream—some of the biggest examples being IOLs, phacoemulsification, and, more recently, presbyopia-correcting IOLs.

CONCLUSION

There may indeed be legitimate reasons to express differences of opinion or even to point out the errors of other physicians. But we need to remind ourselves not to let arrogance or perceived superiority enter such decisions.

Most important, competition with other physicians should never play a role in such discussions. If we were to take a broad perspective, we would realize that the busiest of competitors in most markets present a minuscule threat to our practices compared with system-wide changes by government or third-party payers.

The surest way to devalue our own reputations as physicians rather than mere providers is by threatening the reputations of other physicians and undermining patient and public trust. We should all put patient interests first and promote the integrity of our profession by valuing others' reputations. ■

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