Assessing Your Risks in Providing Medical Glaucoma Care

A review of current case law is enlightening.

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The risk of physician liability for medical malpractice related to the treatment of glaucoma has reached significant proportions in recent years. Both the number of cases and the amount of indemnity payments exceed the norms for ophthalmic claims (Craven ER, in *Survey of Ophthalmology*, 1996). Glaucoma claims arising from medical treatment outnumber surgery-related claims by more than 50% and are more likely to result in indemnity payments. In addition, indemnity payments for glaucoma claims are, on the average, 20% higher. Overall, 15% of high-loss ophthalmology claims involve the management of glaucoma, according to a 1996 Medical Liability Mutual Insurance Company study of 383 ophthalmology claims.

The nature of the legal theories on which physician liability claims can be based helps to explain such statistics. Actions can be brought against physicians for negligence or lack of informed consent, both of which rely heavily on expert testimony from both sides and place much discretion in the hands of the jury. When presented with conflicting expert testimony from both the plaintiff-patient and defendant-doctor, a jury is left to determine which expert "sounds" most credible. Insurance companies, understanding these facts, are more inclined to settle claims and avoid larger jury-driven awards.

More compelling, however, to a jury in particular, is the patient's viewpoint: "A key trigger in lawsuits is the surprised patient who feels betrayed because he or she finds out that more might have been done" (*Survey of Ophthalmology*, 1996.) Such emotional impact has potentially more effect on a jury than any amount of expert testimony related to standards of care and breach of duty.

This trust-and-betrayal viewpoint enjoys support from the courts. Case law acknowledges that when a physician undertakes ongoing care of a patient, the patient comes to believe and rely that the most efficacious care will be obtained when the physician remains on the case (Connell v. Colwell, citing Ewing v. Beck). When this assumption fails, the courts allow an action to be brought at any time. The usual statute of limitations that would force claims to expire after two years does not apply. When "injurious consequences arise from a course of treatment, the statute [of limitations that would prevent a claim from being made after two years] does not begin to run until the treatment is terminated."

Both the lack of a time limit and the potential emotional impact on a jury that perceives that the patient's trust has been violated drive settlements of such claims before they can be fully litigated. Of course, your best approach to reducing the risk of such liability is to avoid any potential for claims in the first place. To help you do that, this article

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examines the specific legal theories on which an action can be brought related to the treatment of glaucoma, as well as the patient viewpoint of your duties.

Medical malpractice claims against physicians related to the treatment of glaucoma can be based on negligence, lack of informed consent, or product liability , and are governed by state law. Nevertheless, we can derive some generalizations from a survey of case law. Here, we'll consider three specific areas of potential physician liability revealed by such a survey:

- Physicians may be held liable for failure to prescribe the most effective treatment for glaucoma.
- Physicians are likely to be held liable if they fail to disclose to patients that a more effective glaucoma treatment may be available than the one they have prescribed.
- Physicians who prescribe an ongoing course of treatment for glaucoma patients, and fail to meet the applicable standard of care, may be exposed to liability for an unlimited time period while treatment continues.

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Claims Based on Negligence

Physicians have a duty to adhere to the applicable standard of care. Negligence cases allege a physician's deviation from that standard of care. Key to sustaining a claim of this type is establishing the standard of care that applies in the case at hand. In general, the standard of care looks at what a reasonably prudent physician in the same specialty practice as the defendant physician would have done in the same or similar circumstances. In various states, this standard of care is expanded to include more specific duties that a physician must comply with in order to meet the standard. For example, in order to act prudently under the same or similar circumstances a physician must know what those circumstances are. This includes awareness of the patient's condition, but also knowledge of available treatments, for example, the characteristics of the drugs to be prescribed.

Further, the physician has a duty to be aware of relevant medical literature, of which a prudent physician in the applicable specialty area would be expected to have knowledge. In Cleary v. Group Health Association, Inc., the alleged negligence of the physician turned on the accuracy of the information he provided to his patient regarding available treatments. In this case, the physician overstated the risks of side effects of an efficacious treatment that subsequently proved effective in reducing the patient's symptoms by 80%. The medical expert in the case testified that the physician should have been well-aware of the treatment, its efficacy and the lower risk of complications than initially reported, from available medical literature — even though the treatment was, at that time, experimental. The court affirmed that the physician's failure to understand and utilize available medical information about the efficacy and low risk of the treatment was an issue of negligence.

In particular, in prescribing a drug, a physician is not entitled to limit his own responsibility to the skill and knowledge of the norm in his field, but rather is required to employ the care and judgment of a reasonable physician possessing the knowledge of the drug which he himself possessed. In Incollingo v. Ewing, the prescribing physician's evidence that a substantial number of physicians in the area would have utilized the same prescription drug as the defendant doctor was not sufficient for summary judgment in his favor because there was no testimony that, given the defendant's own knowledge and awareness, a substantial number of doctors under similar circumstances would have followed the same course of treatment.

The court described its position this way:

"It is argued on behalf of [the defendant] that 'unlike other areas of negligence, in a malpractice action, the medical profession sets its own standard of conduct by establishing its own custom of practice.' This would be to say that as long as a course of conduct, however unreasonable by ordinary standards, is the norm for the group, all members of the group are thereby insulated from liability so long as they do not deviate therefrom. That is not the law."

In addition, an ophthalmologist is held to a higher "specialist's" standard of care. From a series of Washington glaucoma cases, a heightened standard of care, the "reasonably prudent practitioner" standard emerged. It requires an ophthalmologist to exercise prudence in certain instances whether or not it is the general practice of the ophthalmology profession. According to one court: "What is usually done may be evidence of what ought to be done, but what ought to be done is fixed by a standard of reasonable prudence, whether it is usually complied with or not." The court stated that the proper test for ophthalmologists is whether a reasonable prudent ophthalmologist, possessing the degree of skill, care and learning possessed by other ophthalmologists in the state and acting in the same or similar circumstances would have followed the same course of action.

The court in Helling v. Carey stated: ". . . a whole calling may have unduly lagged in the adoption of new and available devices . . . Courts must in the end say what is required; there are precautions so imperative that even their universal disregard will not excuse their omission." It was this Helling court that found an ophthalmologist negligent for failing to administer a glaucoma pressure test despite the fact that all the evidence suggested that administering such a test was not required by the standard of care prevalent at

that time. The ruling resulted in the now widespread practice of administering this test routinely to patients.

Applying this standard to the management of glaucoma treatment, it is clear that the ophthalmologist must not only take into consideration everything he or she knows about available drug regimens, but must also take steps to ensure awareness of the availability of all applicable treatments.

Further, the ophthalmologist must be aware of the patient's particular circumstances. Treatment management is often complicated by patient noncompliance with instructions for drug use, which can mask the effectiveness of drug therapy or contribute to preventable vision loss. Therefore, the patient must be monitored at reasonable intervals to determine whether the therapy is efficacious or requires modification. Failure to understand available treatments, failure to use the knowledge that the ophthalmologist possesses regarding available treatments, or following common practice among other ophthalmologists when evidence suggests that the common practice is not prudent, each constitute a breach of the standard of care for this group of specialists.

In particular, case law suggests that if one treatment method or drug is more efficacious than another, the physician is at risk if he selects the less efficacious drug because such choice may violate the applicable standard of care (Mills v. The County of Cook). In the Mills case, the government tort immunity act did not protect hospital physicians who negligently prescribed oral antibiotics, bronchodialator and Tylenol instead of the alternate more efficacious treatment of ongoing inpatient respiratory support and intravenous antibiotics, thereby breaching the applicable standard of care. The case was not one of failing to prescribe treatment, but rather one in which the "treatment prescribed was inadequate."

While a number of other cases attach no physician liability to the physician's choice of one prescription drug therapy over another by relying on the "differing schools of thought doctrine," the key distinction between these cases and the Mills case is the lack of any claim, or any evidence to support a claim, that one drug was more effective than another. Where efficacy of varying treatments is equivalent, the physician is free to choose; where the efficacy of one treatment over another is evident, the physician is at risk in choosing the less efficacious treatment even if his peers are making the same choice.

Informed Consent: The Patient Viewpoint

As stated previously, malpractice claims against physicians treating glaucoma can also be based on informed consent. The physician-patient relationship is a fiduciary one based on trust and confidence, and obligating the physician to exercise good faith. It is a relationship predicated on the proposition that the patient seeks out and obtains a physician's services because the physician possesses special knowledge and skill in diagnosing and treating diseases.

Juxtaposed with this reliance of the patient on the physician's expertise is patient-physician trust of a different type: the patient's reliance on full disclosure by the physician. The law of informed consent requires that a physician disclose all facts, risks and alternatives that a reasonable person in the same situation as the patient would consider significant in making a decision to undergo treatment.

Because the informed consent standard is subjective to the patient's situation, issues concerning the patient's quality of life, functional status and psychological health as a result of the disease process of glaucoma as well as the patient's clinical progress can all affect the validity of the doctor's disclosures to the patient. Such a standard contemplates that with respect to glaucoma patients, the patient's tendency for noncompliance and frequency of office visits are factors that should be appropriately taken into account when advising and recommending a particular drug therapy.

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When it comes to treatment options, this standard imposes an obligation to disclose significant findings and to explain and advise patients of the most efficacious treatment options available. The biggest problem seen in glaucoma malpractice cases involves poor communication with the patient, a failure to explain the potential consequences (Ewing V. Beck). It is this failure to communicate that can result in the patient's conclusion, whether valid or merely perceived, that his or her trust has been breached. Consent is not valid if based on partial information that omits significant treatment alternatives.

Awareness is Key

The fiduciary nature of the patient-physician relationship imposes heavy burdens on you as a glaucoma physician. Your responsibilities are further complicated by what can be seen in your field as a lack of consensus and science on which medications are most efficacious, and the reality that a medication effective in some patients may not be in any number of others. That said, understanding current case law in this area should improve your ability to protect yourself from claims. **OM**

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