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Unsolicited Patient Complaints in Ophthalmology

An Empirical Analysis from a Large National Database

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Purpose: The number of unsolicited patient complaints about a physician has been shown to correlate with increased malpractice risk. Using a large national patient complaint database, we evaluated the number and content of unsolicited patient complaints about ophthalmologists to identify significant risk factors for receiving a complaint.

Design: Retrospective cohort study.

Participants: Ophthalmologists, nonophthalmic surgeons, nonophthalmic nonsurgeons.

Methods: We analyzed 2087 unsolicited or spontaneous complaints reported about 815 ophthalmologists practicing in 24 academic and nonacademic organizations using the Patient Advocacy Reporting System (PARS). Complaints against 5273 nonophthalmic surgeons and 19 487 nonophthalmic nonsurgeons during the same period were used for comparison. Complaint type profiles were assigned using a previously validated standardized coding system. We (1) described the distribution of complaints against ophthalmologists; (2) compared the distribution and rates of patient complaints about ophthalmologists with those of nonophthalmic surgeons and nonophthalmic nonsurgeons in the database; (3) analyzed differences in complaint type profiles and quantity of complaints by ophthalmic subspecialty, practice setting, physician gender, medical school type, and graduation date; and (4) identified significant risk factors for high numbers of unsolicited patient complaints after adjusting for other covariates.

Main Outcome Measures: Unsolicited patient complaints.

Results: Ophthalmologists had significantly fewer complaints per physician than other nonophthalmic surgeons and nonsurgeons. Sixty-three percent of ophthalmologists had 0 complaints, whereas 10% of ophthalmologists accounted for 61% of all complaints. Ophthalmologists from academic centers, female ophthalmologists, and younger ophthalmologists had significantly more complaints ($P < 0.01$), and general ophthalmologists had significantly fewer complaints than subspecialists ($P < 0.05$). After adjusting for covariates using multivariable analysis, working at an academic center was a statistically significant risk factor (adjusted relative risk, 1.82; 95% confidence interval, 1.36–2.43; $P < 0.001$).

Conclusions: Ophthalmologists had significantly fewer complaints than nonophthalmic surgeons and nonophthalmic nonsurgeons, and by implication may have a lower malpractice risk as a group. Nevertheless, a small number of ophthalmologists generated a disproportionate number of complaints. Working at an academic center was a significant independent risk factor for having more patient complaints. Further research is needed to clarify the underlying reasons for this association and to identify interventions that may decrease this risk. *Ophthalmology 2016;123:234-241 © 2016 by the American Academy of Ophthalmology.*

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Ophthalmologists, like all physicians, have a paramount concern for delivering high-quality patient care. When there is perceived or real deficit in this regard, malpractice lawsuits may ensue. In fact, over the course of their careers, the vast majority of physicians across all specialties will face at least 1 malpractice claim, and ophthalmologists are no exception.[1] Malpractice litigation is costly, both in terms of actual payouts as well as physician time, stress, and loss of reputation.[2] Some specialties have a higher risk of malpractice claims than others.[3] However, even within a given specialty, lawsuits are not distributed randomly, and a minority of physicians account for most malpractice costs.[4] A study among internists, obstetricians, and surgeons showed that 2% to 8% of physicians accounted for 75% to 85% of all indemnity payments.[4] The ophthalmology risk management literature identifies several diagnoses and treatments that seem to be associated with risk management activity. These include retinopathy of

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prematurity, glaucoma diagnosis, cataract surgery implant, and neuro-ophthalmic disorders.[5–8] However, less is known about physician characteristics that predict risk.

Prior research by our group and others has shown that the number of unsolicited patient complaints against a physician is a significant predictor of the physician's subsequent risk management experience.[3,9] This is true for physicians in academic and nonacademic groups, even after controlling for clinical volume.[3,9,10] Mirroring patterns of risk management activity,[4] most unsolicited patient complaints are directed toward the minority of physicians.[11,12] Thus, unsolicited patient complaints are a proxy for malpractice risk. In addition, when physicians who are outliers based on a high number of complaints are informed of their status, they are likely to take steps to mitigate their risk.[13] Unsolicited patient complaints therefore can be used both as a quality improvement tool to enhance patient outcomes and satisfaction and to provide active surveillance to identify and warn ophthalmologists who are at high risk for malpractice litigation.

The primary aim of our study was to identify independent risk factors for ophthalmologists receiving unsolicited patient complaints. Because high-risk diagnoses tend to cluster within a subgroup of subspecialties within ophthalmology, we hypothesized that ophthalmic subspecialty would be a significant risk factor for receiving unsolicited patient complaints. In addition, we sought (1) to describe the distribution of complaints against ophthalmologists; (2) to compare the distribution and rate of unsolicited patient complaints about ophthalmologists with those of other nonophthalmic surgeons and nonophthalmic nonsurgeons in the database; and (3) to analyze differences in complaint type profiles by ophthalmic subspecialty, practice setting, physician gender, medical school type, and graduation date.

Methods

The Vanderbilt Center for Patient and Professional Advocacy (CPPA) maintains a robust, reliably coded[14] database of patient complaint and specialty data for more than 25 000 physicians across the country, referred to as the Patient Advocacy Reporting System (PARS) database. Diverse healthcare institutions across the United States contract with the Vanderbilt CPPA to tabulate and analyze complaints associated with their physicians. By collecting these unsolicited patient complaints, the CPPA data analysis and surveillance system identifies physicians who seem to be at higher risk for malpractice litigation compared with their colleagues and reports results to participating institutions (Fig 1). At the Vanderbilt CPPA, trained coders review and categorize each report using a standardized coding system. The interrater and test–retest reliability of the coding system have been established previously.[14] Each complaint embedded in a complaint report is assigned to 1 of 6 complaint categories: care and treatment, communication, access and availability, concern for patient and family, safety of environment, and billing. Billing complaints are counted only if the report also includes a complaint about an aspect of the physician's care and treatment. The complaint type profile for each physician is the distribution of complaints across these categories. For example, a particular physician may have a complaint type profile that shows a preponderance of complaints related to communication skills, whereas another may have a preponderance of complaints related to access and availability.

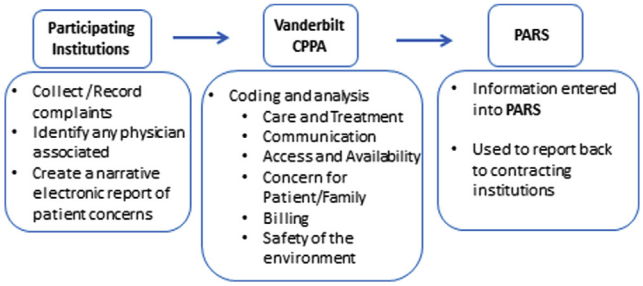

Figure 1. Flowchart showing patient complaint data collection, coding and analysis, and reporting using the Patient Advocacy Reporting System (PARS) database.

To address the study's aims, we performed a retrospective cohort study in which we reviewed patient complaint data for a cohort of ophthalmologists and neuro-ophthalmologists employed at institutions that participate in the PARS database. The 4-year study period extended from November 1, 2009, through October 31, 2013. To be included in the study, each physician had to have an active practice all 4 consecutive years during the study period and to be identified by the contracting institution as an affiliated ophthalmologist or neuro-ophthalmologist. Four years was selected because this allows for patterns of behavior for each ophthalmologist to be established while not being so long that it no longer reflects an ophthalmologist's current risk. In addition, 4 years is consistent with prior publications related to patient complaints.[13,15,16] Because the data were de-identified, the Vanderbilt University Institutional Review Board ruled that approval was not required for this study.

Database Construction

The investigators were masked to the identity of the ophthalmologists in the cohort; 3 distinct datasets were created. Each ophthalmologist who met the study inclusion criteria was assigned a unique identification number. The first dataset included only each cohort physician's name, identification number, and institution. This dataset was used to look up subspecialty information, year of medical school graduation, type of medical school attended (foreign vs. domestic), type of medical degree earned (MD, DO, or MD and PhD), and gender for each ophthalmologist in the study. To minimize the risk of subspecialty misclassification, the American Academy of Ophthalmology member directory, the American Board of Ophthalmology website, institutional websites, and third-party physician review websites were used by 2 independent reviewers to gather and cross-check covariate information. We excluded 11 optometrists and 1 PhD vision scientist from the list of ophthalmologists and reclassified 1 otolaryngologist to the nonophthalmic surgeon category. To ensure the integrity of our database and to make sure that the 3 groups were mutually exclusive, we also manually searched the websites of each institution against our list to ascertain that no ophthalmologists or neuro-ophthalmologists who met inclusion criteria had been excluded inadvertently. We found 3 additional neuro-ophthalmologists who met inclusion criteria who were reclassified into our ophthalmologist database (Fig 2). In addition, we performed a sensitivity analysis by randomly selecting a sample of 150 nonophthalmic nonsurgeons drawn from the participating institutions, which included 76 nonophthalmic surgeons and 74 nonophthalmic