OPHTHALMOLOGY COMPLAINTS IN SPAIN
DENUNCIAS EN OFTALMOLOGÍA, EN ESPAÑA

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ABSTRACT

**Purpose:** We reviewed 90 complaints for allegedly incorrect ophthalmic procedures. Most of these complaints (33%) were related to cataract and refractive surgery (18%). In third position in terms of frequency (14%) were complaints concerning oculoplastic surgery and in fourth position were complaints related to retinal detachment (13%). This was followed by a miscellaneous group, which represented 10% of complaints. About 9% of complaints were related to emergency ophthalmic procedures, while just 3% of complaints were related to glaucoma.

**Methods:** We analysed within each subgroup the characteristics of the claims; the information given to the patient, those cases in which there existed grounds for considering the ophthalmologist’s performance as being incorrect, and court orders that were adopted.

**Results:** The most common groups were cataract and refractive surgery, which together represented more than a half of the complaints. We found in 26% of cases, reports from other doctors criticising the professional performance a posteriori of an accused ophthalmologist, incorrect or incomplete documents of informed consent, as well as patients asserting that their surgeons made them promises of results, or minimized risks about the proposed operation.

**Introducción:** Se ha realizado una revisión de 90 denuncias por actuaciones oftalmológicas presuntamente incorrectas. La mayoría de ellas son por intervenciones de cataratas (33%) y de cirugía refractiva (18%). En tercer puesto las actuaciones relacionadas con el desprendimiento de retina (13 %), seguidas en quinto lugar por el grupo de miscelánea (10%), en sexto por el de urgencias oftalmológicas (9%) y en séptimo y último puesto denuncias por actuaciones oftalmológicas relacionadas con el glaucoma (3%).

**Material y métodos:** Se analizaron, dentro de cada subgrupo, las características de las denuncias, la información dada al paciente, los casos en los que existieron motivos para considerar incorrecta la actuación del oftalmólogo, y las resoluciones judiciales que se adoptaron.

**Resultados:** Los grupos más frecuentes son cirugía de cataratas y refractiva, que conjuntamente representan más de la mitad de las denuncias. Encontramos en el 26% de los casos informes de otros facultativos criticando a posteriori la actuación del oftalmólogo, documentos de consentimiento informado incorrectos o incompletos, así como pacientes que aseguran que sus cirujanos les hicieron promesas de resultados o les minimizaron los riesgos de la intervención propuesta.
Conclusions: In the great majority of cases, the claim was settled due to a characteristic complication inherent in the surgical technique and present in the document of informed consent signed by the patient. We also observed a minority of cases, particularly in refractive surgery, in which a foreseeable and avoidable complication related to incorrectly prescribed surgical techniques was produced. In these exceptional cases, expert evidence is usually unfavorable and charges are typically laid. It is probable that improved information for patients would reduce the number of these claims (Arch Soc Esp Oftalmol 2009; 84: 459-468).

Key words: Malpractice in ophthalmology, medicolegal issues, expert witnesses, medicolegal claims.

INTRODUCTION

At present one of the main concerns of ophthalmologists is to avoid involvement in a complaint due to presumably faulty professional performance. We have proved that in the vast majority of said complaints in our country there are no actual actions against Lex Artis but an information problem (1). This was already known at the international level (2). Accordingly, the obvious increase in the number of complaints in recent years responds to socio-economic factors (higher awareness of patient rights, evolution of the attention model from authoritarian/paternal to the current participation model, proliferation of civil liability insurance, etc.) and must not be interpreted as the result of decreased medical assistance quality, which has exhibited clear improvements in recent years.

We have verified that in most cases complaints are due to a typical complication in this type of operation of which the patient was not duly informed or where the risk had not been assumed. When said complications arise, the patient regards them as the result of deficient professional performance (mal praxis). For this reason the experts report is favourable to the ophthalmologist in the vast majority of cases (82%) and inculpatory court decisions are the exception, at least in the criminal field (2-4%) and in the majority of cases for misdemeanours (not criminal offences) which do not involve professional bans or criminal records. Even so, the anxiety caused by being involved in a court procedure which usually takes about two years (1) is a disagreeable experience which demonstrably involves important damages for the ophthalmologist. For instance, we know that during this period there is an increased risk of being the object of new complaints (Note: a study has shown that litigations give rise to more errors associated to the lawsuit. Medical Diary dated April 22, 1996. Regulations). (Passineau TL. The effects of medical malpractice litigation on subsequent physician performance. Presentation at the International Conference on Physician Health, September 1994).

An ophthalmologist working in the British National Health Service will be the object of at least one complaint in the course of a 30-year professional career. More specifically, the probability of an ophthalmologist being reported in the next 10 years has been calculated by approximation to be of 30%. This probability increases to 90% if the professional is a consultant instead of an ophthalmologist. In the United States the situation is even worse because the average number of legal complaints against an average ophthalmologist is of 2.8 throughout his career (3).

In spite of the interest that civil liability has among ophthalmologists, there are not many articles on the topic and most of them are from the United States (2). In Spain we only know of two series related to this topic (4,5). For this reason we have considered it relevant to make a review of the complaints in which we have participated as experts in recent years, classifying them in different cate-

Conclusiones: En la inmensa mayoría de los casos la denuncia se plantea por una complicación típica, inherente a la técnica quirúrgica y que figuraba en el documento de consentimiento informado firmado por el paciente. También vemos una minoría de casos, generalmente intervenciones de cirugía refractiva, en los que se produce una complicación previsible y evitable, en cirugías incorrectamente indicadas. En estos casos excepcionales, el informe pericial suele ser desfavorable y hemos encontrado alguna condena. Es probable que un mayor cuidado en la información al paciente redujera el número de estas denuncias.

Palabras clave: Malaparxis en oftalmología, cuestiones medicolegales, peritajes médicos, reclamaciones medicolegales.
categories based on the type of ophthalmological intervention giving rise to the complaint, as well as analysing the frequency and characteristics of each category. The purpose of this article is to share our experience with our colleagues and endeavour to draw some conclusions of use in daily practice. An in-depth knowledge of the issue could be the best way to prevent new complaints in similar situations and thus improve the quality of the attention we provide to our patients.

SUBJECTS, MATERIAL AND METHOD

A retrospective study of all the complaints which gave rise to a request for a report from the Ophthalmology Section of the Forensic Medical Clinic of Madrid in the past nine years. Said section reports on the cases referred by non-expert forensics of the Community of Madrid. We do not include the cases in which reports are requested for an assumed medical negligence produced in a specialty other than ophthalmology and leaves a sequel at the ocular level. For example, a traumatic cataract case produced during laser eyebrow beauty treatment or similar cases of ischaemic optic neuritis in the context of disc hernia operations. During the said period we have reported on 90 lawsuits related to ophthalmological operations. In practically all cases, the lawsuit was filed in the criminal jurisdiction, although in seven cases (7.77%) we reported on some cases requested by administrative jurisdiction courts which are competent in complaints for services provided in public hospitals. We did not intervene in claims submitted at civil courts where the reports are issued by private experts usually designated by the parties. As we know, criminal lawsuits are of greater importance for the ophthalmologists (6). The claimant was evaluated by us in all cases except one who had died, and in all cases the expert report was made by the same ophthalmologist.

The main aims of this work are to determine the average number of complaints per year, classify the complaints on the basis of the type of ophthalmological intervention which gave rise to the complaint, determine the percentage of complaints for each group and finally analyse the most frequent causes of complaints, the information provided to the patient, the proportion of cases in which the intervention was reported as incorrect and whether the court decision was favourable or not to the ophthalmologist.

RESULTS

From January 1, 2002 December 31, 2008 the Ophthalmology Section of the Forensic Medical Clinic of Madrid made 90 reports, an average of 10 a year. The reports were classified in seven groups based on the specialty of the originating ophthalmological intervention. Figure 1 illustrates said groups in percentage values.

Group 1. Cataract surgery: 29 cases

This is the most numerous group was 29 complaints. In most cases, the reason was the poor result of the intervention due to a typical complication of this type of surgery. Five cases involved retinal detachment in relation to the operation (these cases were not included in the retinal detachment group), 3 cases of endothelial decompensation, 3 expulsive hemorrhages, 3 endophthalmitis, 3 posterior core dislocations and 2 posterior capsule ruptures with sequels. In two cases we considered that the complaint had a clear economic motivation, 1 of them involving a patient which did not communicate to the surgeon the existence of amblyopia and subsequently filed a lawsuit due to the poor results of the intervention in what concerns visual acuity. The other case involved a dislocation of the nucleus to the vitreous cavity, in which the patient was clearly interested in obtaining compensation.
Within this group we found some peculiar cases such as the complaint of a patient against her Social Security ophthalmologist for not removing an irritating suture point, which obliged her to go to a private ophthalmologist who, according to the patient, resolved the problem. In one case there was a mistake in the lens calculation which caused a 4 diopter myopic refractive defect which was subsequently corrected by means of LASIK but even so the patient filed a complaint alleging loss of vision quality in that eye. In another case the ophthalmologist was reported due to an alleged swindle for invoicing the patient for an anterior chamber lens which was never implanted. In this case there was no court decision because during the trial it was admitted that the alleged offence had prescribed. Finally, 1 case in which the surgeon forgot to perform an iridotomy in an anterior chamber intraocular lens implant, giving rise to a blockage in pupil which caused amaurosis. This is the only one of the three cases with oral trial in which a court decision found the ophthalmologist guilty of imprudence.

Group 2. Refractive Surgery: 16 complaints

This is the second largest group, with 16 cases. The vast majority (88%) are Excimer laser interventions, 2 involving photorefractive keratectomy (PRK), 8 for myopic LASIK and 4 hypermetrope LASIK. The two remaining cases were intraocular interventions which produced endophthalmitis. One of these complaints was a secondary IOL implant which was dismissed and the other was a lens surgery case (performed bilaterally in the same intervention) which produced endophthalmitis in one of the eyes. The informed consent document signed by the patient was for cataract surgery. This complaint originated a lawsuit resolved with an acquittal.

In the majority of laser Excimer surgery cases, the complaint was based on complications which are typical of these operations such as offset ablations, flap section defects or post surgery keratitis, which are usually included in the informed consent. For this reason the expert report is usually favorable to an ophthalmologist and the complaints are dismissed. On the contrary, in three of the 16 complaints in this group the expert report was unfavorable to the ophthalmologist. These cases involved a predictable residual refractive defect which could have been foreseen due to operating beyond the currently accepted limits for these techniques (hypermetropia exceeding 5 dioptres (7.8) or myopia exceeding 10-12 dioptres). One of the cases concerned a bilateral simultaneous LASIK operation on a patient with deep amblyopia in the RE caused by myopia magnus (-22 D) and important myopia (-9.5 D) in the LE. The other two complaints were against the same ophthalmologist for two similar interventions on hypermetrope women with 5+ dioptres of spherical equivalent with presbytia and slight amblyopia who were left with residual refractive defects and reduced visual quality. The informed consent they signed was for a myopic LASIK operation instead of hypermetropic. One of these cases is awaiting a court decision and the other was taken to trial and the ophthalmologist was acquitted.

Group 3. Eye plastic surgery: 13 cases

Six of these 13 complaints are due to poor blepharoplasty results. In addition to an aesthetic sequel, the cases reaching the law courts usually involved important functional repercussions due to compromising ocular occlusion and producing repetition keratitis.

In these cases the expert report is generally favorable because these complications are described in this type of intervention and the patient had been duly warned and accepted them, as shown in the signed informed consent. These two cases ended with acquittals.

The other seven cases in this group were due to minor or non-existent sequels such as a small astigmatism in a pterygion intervention or a very small scar after removing a styte from the free edge of the inferior eyelid or a small palpebral eversion during a congenital entropion operation. In one case, the complaint was for a dachryocystorhinostomy on the wrong side. In most of these cases an economic interest was likely but was never achieved, at least in the criminal courts. Said complications are inherent to these operations and patients had been warned as is shown by the signed informed consent documents.

Group 4. Retina detachment: 12 cases

Of the 12 complaints in this group, 4 involve diagnostic errors for not dilating a patient in an
emergency ward, generally alleging symptoms which are not typical of retinal detachment. In four other cases the complaint was due to poor results of operations which surprised badly informed patients who thought that the retinal detachment surgery achieved a full vision recovery in all cases. The remaining four cases involved an alleged poor execution of the operation. In two of these cases the complaint was supported with a report of a third-party ophthalmologist who, after the operation, stated that the treatment applied to the patient was not correct. One of these was the fifth retinal detachment operation carried out one month after indication due to waiting list problems and the other was a superior retinal detachment treated by neuremoretinopexia, which included a report attributing the poor result to not having treated with vitrectomy as the first therapeutic option.

Within the third group it is very frequent to find information problems or deficient doctor-patient relationships because of the 12 complaints we only found an informed consent in one, and even this one was excessively generic to be considered valid. In all these cases the expert report was favorable to the ophthalmologist and the complaints were dismissed before being admitted to trial.

**Group 5. Miscellaneous: 9 cases**

In this group we included nine complaints which could not be grouped elsewhere. Some were due to obvious information problems, such as two cases of patients who reported the ophthalmologist because a keratoplasty graft had been rejected or an exotropy had relapsed after the operation. Other complaints allege execution errors (performing photocoagulation on a premature) or manual (instead of Excimer laser) superficial keratectomy. One case filed a complaint for a six-month delay in diagnosing acanthamoeba keratitis after exhibiting favorable evolution with the antiviral and antibacterial treatment followed during that period. Finally, there is a group of totally unfounded complaints aimed at obtaining some compensation for an alleged effect of a pupil dilatation after a cyclopegic eyedrop prescription. In one of these cases, the patient referred “seeing everything white” for six months and the other a fibromyalgia had been triggered as well as a “chronic fatigue syndrome” and a “multiple chemical sensitivity syndrome”. In all these cases, the expert reports were favorable and the cases dismissed.

**Group 6. Ophthalmological emergencies: 8 cases**

Of the eight complaints in this group, 6 alleged diagnostic errors in the emergency section. Three of these were endophthalmitis due to foreign bodies which were not detected in the initial visit. In two of these, the patient did not mention carrying out an activity involving the risk of foreign bodies penetrating the eye (drilling and hammering) and therefore no x-ray exploration was made. This type of complaint is relatively frequent because the sequels are important (generally amaurosis) and derived from insurance-covered labor accidents. The other three诊断 errors might have involved difficult doctor-patient relationships during the emergency visit as the patients were problematic, of low social-cultural level and some had language difficulties for communicating their symptoms.

The two remaining complaints alleged errors in the execution of emergency medical action on the part of doctors who were not ophthalmologists. One of the cases involved traumatic cataract due to a needle that penetrated the cornea while attempting to remove a foreign body by means of irrigation with a needle on the syringe, and the other was due to keratitis derived from biological adhesive splashed on the cornea while trying to close a palpebral injury in a child. In this group we have found no convictions.

**Group 7. Glaucoma: 3 cases**

Two of these three complaints alleged diagnostic errors. One was for the campimetric sequence caused by delays in reaching a diagnostic. The patient’s IOP was not measured on two occasions in the course of four months when in both cases he visited the practice due to eye redness. Subsequently, a pressure of 52 mmHg was found. This omission was deemed to be negligence in the expert report but even so the court considered that there was no criminal responsibility and the case was dismissed. In the other case, the diagnostic error was the opposite: Trabeculectomy was indicated for a patient (although never performed) after failing to
reduce IOP with two anti-glaucomatous eye drops. Subsequently it was demonstrated that the patient did not have glaucoma. In this case, the expert report took into account the diagnostic complexity in the initial stages of glaucoma as well as the absence of execution of the alleged error and therefore of sequels for the patient. The case is a clearly fraudulent complaint at tempting to attribute a campimetric defect to a delay in the emergency section which failed to reduce high intraocular pressure. The patient had an absolute scotoma in the involved eye, of which he was fully aware as proved by the campimetric exploration carried out only five days earlier by his usual ophthalmologist. The expert was requested to issue a report which clarified the situation and led to a dismissal of the case from court.

Over the 90 complaints, 74 (82%) were resolved and 16 (18%) are still pending (Fig. 2). Of these 74, 67 (75%) were dismissed and only seven were admitted to court (7%). Of these, three complaints (3%) were admitted to a misdemeanor trial which ended with acquittals, in four of said seven cases an oral trial was held, of which two (2%) ended with acquittals and a further two (2%) were convicted for a misdemeanor. We have not found any case ending in a criminal conviction.

**DISCUSSION**

The percentage distribution of the complaints between the ophthalmological sub-specialties varies depending on the period and environment in which the study is made because of the surgical techniques involved. In addition, it is different to review statistics from insurers, public health data or complaints filed in law courts. The percentages we obtained in our study match those we found in the international literature.

In 1990, J. W. Bettman published a review of 700 cases (9). In most of these cases, Bettman personally intervened as expert ophthalmologist during his 40-year career. The complaints are prior to 1990, which means that complaints due to Excimer laser refractive surgery had not yet appeared. Recently, in December 2007, Ali N published a review of 848 complaints (3), analyzing the peculiarities of each ophthalmological subspeciality. However, this study is limited to the data obtained from the British public health system (NHS) so, as with the Bettman study, does not include complaints due to refractive surgery or palpebral aesthetic surgery which account for a considerable proportion of complaints, generally arising from private ophthalmology practice.

Some authors consider that 34% of the complaints which give rise to compensations follow laser interventions and 3% follow blepharoplasty (10). Accordingly, we cannot rule out the importance of private practice as a source of eventual complaints.

In all the published series, the most frequent cause of complaints is cataract operations which account for 22-39% of cases. This surgery has been considered as a risky activity as regards complaints not due to the possibility of being the object of a complaint after the operation (which is quite low) but due to the high frequency of this type of operation and the important sequels its complications may produce (11).

In our study this group is also the most numerous, accounting for 33% of all complaints. In most cases these arose out of typical although infrequent complications leaving serious effects of which the patient was usually informed beforehand, as registered in the informed consent. Most of these cases are dismissed before the oral trial and for this reason we haven’t found any convictions. The Spanish law court jurisprudence establishes acquittals in cases of typical operation risks when the action of the physicians does not depart from the *Lex Artis* (Esteban M. The typical risk of an operation is not compensated if there is good practice. Medical

Fig. 2.

Resolution of complaints

- Pending: 3%
- Dismissed: 2%
- Acquittal (misd. Court): 2%
- Acquittal (oral trial): 18%
- Sentenced (oral trial): 75%

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Diary dated Dec. 13, 2006. Regulations. This criterion is applied also in complaints against the public health system (Administrative Jurisdiction) (Andalusia. The foreseeable and inevitable risk of an operation does not give rise to compensations. Medical Diary dated Nov. 20, 2006. Regulations).

The amount of the compensations received by sequelae derived from cataract operations range between 180,000 and 28,000 US dollars (about 67,000 Euros on average) (10) and about 20,000 pounds, considered to be the mean compensation in the UK for this type of operation (about 25,000 Euros). These numbers are similar to the compensation being granted at present in Spain: 15,000 Euros for not informing adequately a patient who suffered an endothelial decompensation (Europa Press news agency, Sevilla. Compensation for damages in a cataract operation. Medical Diary dated Nov. 6, 2007. Regulations), or 38,390 Euros for an endophthalmitis secondary to cataract surgery in a private clinic, where the absence of asepsis during the operation was demonstrated (Gonzalo de Santiago. Sentence for a lack of asepsis and post-op control. Medical Diary dated Feb. 6, 2008. Regulations).

Strategies have been proposed for reducing the risk of this type of complaints, consisting in an adequate documentation of pre-op explorations, including references in the informed consent to specific personal risks for the patient, properly filling in the surgical protocol papers, recording the post-op follow up, increasing the frequency of usual checkups when complications arise or when the patient perceives alarming symptoms, avoiding subsequent medical record corrections and early referral of the patient to a consultant when necessary (10).

The second group in the number of claims is refractive surgery. Our revision is restricted to penal complaints and for this reason this percentage is probably only the tip of the iceberg because the majority of claims for this type of operations are resolved in the civil courts or even out of court. Taking this into account, it does not seem exaggerated to state that laser surgery compensations could account for 34% of the total (9).

From the legal viewpoint, refractive surgery interventions are considered in a similar way as dentistry or aesthetic surgery interventions, as can be seen from recent decisions: “this is a border zone between voluntary and therapeutic medicine because, even when it aims at eliminating a visual defect, its purpose is also aesthetic because an additional purpose is to eliminate the need of using eyeglasses in 99% of cases”. Accordingly, “it brings the surgical operation close to a services contract which facilitates greater guarantees for obtaining the pursued result” (sentence of Section 7 of the Civil Court of Valencia Province, May 10, 2005).

We agree with the majority of authors (12) in that higher demands can be required for fulfilling the duty of informing the patient in an understandable and realistic manner about the expectations that can be entertained in relation to the operation. The surgeon must make sure that the patient will accept the possibility (however remote) of eventual complications inherent in the surgical technique and the possibility of a diminished best corrected visual acuity.

In these cases we have seen that in the event of a complication that is typical of this type of operation, if it was adequately described in the informed consent, the expert report is usually favorable to the ophthalmologist and the complaint is dismissed, at least in the criminal court. It is a very different situation when the informed consent is faulty or nonexistent (we have found informed consents for myopic LASIK when the operation was hypermetropia LASIK, or for cataract surgery when the operation was for removing the transparent lens) or when the operation fell outside the range of indications for that procedure. In such cases, when sequelae are involved, the expert report is usually unfavorable and we have found some inculpatory sentences.

The third group in frequency of complaints are eye plastic surgery which account for 14% of all complaints. The prevalence is very high compared to other series but this is probably explained by the fact that nearly half of the complaints in this group referred to blepharoplasty (6.66% of the total). This type of intervention has increased considerably in recent years and this could also account for its increase vis-à-vis the 2.5% found by Bettman (9) in his revision of cases prior to 1990. In addition, these interventions are not usually carried out in the public health system, which explains why the most recent revision (2007) of Nadee Ali this group accounts for only 5% (3).

It is necessary to provide full information to the patients and document everything carefully before carrying out elective surgical interventions (8). The majority of complaints are due to an excessive
resection which produces lagophthalmos and thereafter keratitis due to exposure, requiring permanent utilization of eye lubricants. Applying the required results criterion for this type of intervention would be controversial (sentence dated June 17, 2003 by the First Instance Court 8 of Palma de Mallorca in case 301/1997).

In all the published series, complaints related to retinal detachments represent an important percentage (between 7 and 16% of cases) (Passineau TL. The effects of medical malpractice litigation on subsequent physician performance. Presentation at the International Conference on Physician Health, September 1994) (4,8,9). In our revision they account for 13% of all complaints and occupy the fourth place in frequency. Reviewing the causes of complaints within this vitreoretinal surgery group which took place in the British public health system (NHS) between 1995 and 2006, the main reasons are problems or errors in the pre-op stage (53%), followed by diagnostic or treatment errors (34%), and with less frequency complaints for poorly founded reasons (9%) or related to equipment failure (3%) (13).

Jerome W. Bettman (9) considers that retinal detachment diagnostic errors are the most frequent cause of complaints within this group. Sometimes this error is the result of a faulty exploration due to carrying out an ocular fundus exploration without previous pupilar dilatation and with indirect ophthalmoscope, or not discarding lesions in the contralateral eye. We agree with his opinion that a small undiagnosed detachment after a thorough ophthalmoscopic exploration under midriasis should not be considered as malpractice. For a diagnostic error to be punishable, at least from the penal viewpoint, it must involve an important entity as established by jurisprudence (Supreme Court Criminal Section sentence dated February 29, 2006): «a diagnostic error cannot be punishable unless, due to its entity and dimension, it can be said to be an unjustifiable mistake».

We have mentioned that a third of these cases arise because the result of the intervention was not as expected by the patient. It is likely that these complaints could have been avoided with adequate pre-op information clearly establishing that this type of operation does not always achieve full recovery of the visual function.

The final third of complaints are due to alleged errors in the execution of the operation. Two of the 3 complaints attach reports by third-party ophthalmologists criticizing the treatment applied to the patient. These statements are included in 26% of all complaints against ophthalmologists that we have reviewed (1). We should be extremely prudent in the preparation of these reports, avoiding comments about the adequacy or not of the work by colleagues which clearly exceed our obligation of informing the patient unless we have been designated as experts in the lawsuit. We usually ignore the use the patient will make of this type of report, but we can assume that the plaintiffs lawyer will not hesitate to use it against a colleague.

The fifth group in our ranking is the miscellaneous group. All the published series include a section of complaints which cannot be included in other groups which have a low frequency (between 6.6 and 16%). We have not found in this group any indications of malpractice or inculpatory sentences.

Complaints due to problems related to the assistance given to ophthalmological emergencies are the sixth group in what concerns frequency. The percentage of this group is also slightly higher than the numbers given by other authors: Bettman considers this group to represent 6.8% while Nadeem gives only 4%. We have seen that the physician involved is usually not an ophthalmologist and this can explain why the majority of complaints (six out of eight) indicate diagnostic errors. Half of these errors are due to not discarding the presence of a foreign body in the eye which, in the space of a few hours, causes endophthalmitis with important effects or even the anatomical or functional loss of an eye. An expert called in to report on the complaint can hardly defend a physician who does not make an orbit x-ray to discard the presence of foreign bodies in the eye of a patient who visits the emergency room referring that he has been carrying out risk activities such as drilling or hammering. Recently the case of a patient was published who was diagnosed in the emergency room of corneal laceration and returned 24 hours later with post-traumatic endophthalmitis caused by an intra-ocular foreign body which went undetected. The court sentence absolved the physician, considering that a diagnosis in an emergency room is not final but a first impression about the condition of a patient (Esteban M. A court decision states that in emergency wards diagnostics are not final. Medical diary dated Nov. 2, 2007. Regulations).

The last group in what concerns frequency of complaints is the glaucoma group, which has a sim-
ilarly low frequency in all series: 7.8% in Bettman (10) and 5% in Nadeem (3). Even though complaints due to glaucoma are infrequent (only 43 cases in 10 years in the British NHS (14)), when they do arise they have the highest probability of obtaining compensation. Thus, 64% of these cases in the United Kingdom and 42% in the United States have obtained compensations. In Bettman’s view, the majority of complaints are due to delays in the diagnostic, and the cases in which only digital tonometries have been performed without a careful exploration of the papilla or without taking visual fields are very difficult to defend (9). We agree with this criterion and for this reason we issued an unfavorable report in one of the two cases. Even so, the case was dismissed and the ophthalmologist absolved.

Even though the number of complaints against ophthalmologists has increased in recent times, it remains low: 90 complaints in the last 8.5 years, giving an annual average of 10 complaints.

The ophthalmological intervention which most complaints produces is cataract surgery, with second place for refractive surgery (generally LASIK operations). Together, both groups account for over half of all complaints. The third-place in our series goes to ocular plastic surgery complaints, usually due to lagophthalmos secondary to blepharoplasty. The fourth place is taken by complaints related to retinal detachment, a third of which are for diagnostic errors, another third by poor surgical results and the remainder for faulty execution. We have verified that diagnostic errors in ophthalmological emergencies involving non-detection of intra-ocular foreign bodies are the most frequent cause of complaints. The least frequent group is glaucoma.

In the majority of cases, complaints are produced due to an unfavorable result of an intervention which was unexpected by the patient but usually described in the informed consent document. Exceptionally, we have found cases of foreseeable and avoidable complications derived from improperly indicated interventions, generally for refractive surgery.

In 26% of complaints we have found reports of other physicians criticizing the professional action of the ophthalmologist after the operation as well as incorrect or incomplete informed consent documents, together with patients stating that the surgeon promised the results or minimized the risks of the proposed operation. Probably the application of more detailed information and greater care for the physician-patient relationship will reduce the number of complaints and increase the quality of the attention we provide.

REFERENCES