IMPORTANCE Understanding outcomes of pediatric malpractice litigation allows ophthalmologists to gain insight into how to best care for patients and prevent such litigation.

OBJECTIVES To report and analyze the causes and outcomes of ophthalmology medical malpractice litigation involving patients younger than 18 years.

DESIGN, SETTING, AND PARTICIPANTS The WestLaw database was reviewed from April 1 to 30, 2015, for ophthalmology-related lawsuits, including settlements and trial verdicts, in the United States from January 1, 1930, to December 31, 2014. Search terms included ophthalmology or ophthalmologist and malpractice anywhere in the retrieved documents. Cases in which the plaintiffs were younger than 18 years at the time of the inciting event were included. Pediatric cases were compared with adult cases.

MAIN OUTCOMES AND MEASURES Pediatric malpractice case outcomes and settlement amounts.

RESULTS Sixty-eight ophthalmology malpractice cases involving plaintiffs younger than 18 years were included in the study. Thirty-five cases (51.5%) were resolved via jury trial. Of these 35 cases, verdicts in favor of the plaintiff were issued in 17 pediatric cases (48.6%) (difference, 33%; 95% CI, −24% to 64%; P = .01). The 17 cases that resulted in verdicts in favor of the pediatric plaintiff had a mean jury award of $4,815,693 (median, $883,281; range, $147,765-$42,061,690). Nine of the total 68 cases (13.2%) resulted in a settlement, with mean adjusted indemnities of $1,912,738 (median, $1,377,689; range, $92,070-$8,493,086). The remaining 24 cases (35.3%) involved appellate rulings, pretrial and posttrial relief rulings, and 1 bench verdict. Jury awards were higher in pediatric vs adult cases (difference, $3,422,134; 95% CI, −$3,422,134 to $8,731,916; P = .002), as were indemnity payments (difference, $1,186,757; 95% CI, −$69,074 to $3,342,588; P = .003). Cases involving legal blindness were more likely to result in verdicts in favor of the plaintiff (difference, 60.5%; 95% CI, −1% to 62%; P = .30). Common clinical scenarios in cases of litigation were traumatic ocular injury (15 [22.1%]), retinopathy of prematurity (12 [17.6%]), and endophthalmitis (6 [8.8%]).

CONCLUSIONS AND RELEVANCE Malpractice litigation involving pediatric patients was more likely to be resolved in favor of the plaintiff and was associated with higher monetary awards than was adult litigation. Cases involving retinopathy of prematurity resulted in the highest payments to plaintiffs, and cases involving legal blindness and/or endophthalmitis were more likely to be resolved in favor of the plaintiff. This information may give pediatric ophthalmologists insight into the situations and conditions that commonly lead to litigation.

Published online September 1, 2016.

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Deally, malpractice litigation is a means of compensating patients who have been injured as a result of physician error and ensuring that physicians are held accountable for negligence or errors in judgment. Although medical malpractice serves an important role in the United States, many authors have argued that the current system is flawed, citing inequitable and untimely distribution of monetary awards to deserving plaintiffs, the rise in cost of premiums for malpractice insurance, and an increase in the practice of defensive medicine.1,6

According to a 2010 survey by the American Medical Association, 5% of all physicians reported a malpractice claim within the prior year.5,7 Ophthalmologists have not been immune to increased litigation. It has been reported that between 5% and 10% of ophthalmologists each year face a malpractice claim and that the median amount of jury awards has increased steadily since the 1990s, as have the number of awards exceeding $1 million, representing a growing financial burden for ophthalmologists, insurers, and the public.5,8

Visual impairment is associated with reduced quality of life, loss of independence, and the reduction of potential earnings. Although children comprise only a fraction of plaintiffs in lawsuits in the United States, visual impairment is a significant disability for young patients and can thus be associated with indemnities and jury awards exceeding $1 million.9-11 As litigation in pediatric ophthalmology is distinct from adult litigation, it deserves special attention. We provide a narrative overview and subgroup analysis of all ophthalmology malpractice litigation in the WestLaw database involving minor plaintiffs across all subspecialties of ophthalmology, with the goal of informing risk management in this vulnerable population.

Methods

Because all data in this study are publicly available and no human patients were involved, the University of Virginia institutional review board waived approval and the need for informed consent. Data are reported by location and year of filing to maintain the confidentiality of the physicians and patients named.

WestLaw (West Publishing Co) is a legal database that contains verdicts, rulings, and formal settlements in all 50 states. The database was queried from April 1 to 30, 2015, using the search terms ophthalmology or ophthalmologist and malpractice anywhere in the retrieved documents to search all US civil trials involving ophthalmologists. Trials were excluded if the ophthalmologist was named as an expert witness but was not a defendant, and if they were filed before January 1, 1930, or after December 31, 2014. All search results that referenced malpractice litigation but that were not themselves malpractice lawsuits were excluded. Duplicate lawsuits or WestLaw citations were also combined and represented as a single case (A.K.R.). Record review included date of occurrence, year of suit, defendant, geography, patient age, patient sex, diagnosis, outcome, presence of disability, nature of injury, legal allegation by plaintiff, indemnity, verdict, and award to plaintiffs. Legal blindness was defined as visual acuity of 20/200 or less in the eye or eyes related to the case, and/or a visual field of 20° or less, as this is the standard used to determine eligibility for disability.12

Not all information was available for every case. Cases were also categorized by an ophthalmologist (A.K.R.) by intervention (surgical and procedural, medical, or noninterventional) and by subspecialty focus. The subspecialty focus of the case was defined based on the nature of the allegation rather than the subspecialty training of the physician defendant as the following: general ophthalmology (ie, cataract surgery, sequelae of cataract surgery [including retinal detachment], contact lens prescription, or laser capsulotomy), pediatric ophthalmology (ie, strabismus in a child), glaucoma (ie, glaucoma surgery, glaucoma laser, or vision loss owing to glaucoma progression), retina (ie, vascular occlusion, retinal laser, retinal dystrophy, retinal tear or detachment, or vitrectomy), cornea (ie, refractive surgery, infectious keratitis, keratococcus, corneal transplant, or collagen crosslinking), neuro-ophthalmology (ie, optic nerve lesion, central nervous system lesion, multiple sclerosis, or strabismus in an adult), ocularplastic (ie, blepharoplasty, orbital tumor, or cosmetic procedure), uveitis (ie, retinitis, scleritis, white dot syndrome, or inflammation requiring an oral corticosteroid), or ocular oncology (ie, choroidal melanoma, retinoblastoma, or intraocular lymphoma). Cases with a focus on care after trauma to the globe or orbit were classified as traumatic. When subspecialty focus was unclear or divided (ie, child with keratococcus and strabismus), subspecialty focus was cataloged as “unknown” or assigned by one of us (A.K.R.) using best judgment. Settlements and awards were adjusted for inflation to 2015 US dollars (http://www.bls.gov/data/inflation_calculator.htm) to permit meaningful comparison.

In this analysis, all malpractice litigation involving plaintiffs younger than 18 years at the time of injury or inciting event was identified from a database of 1063 ophthalmology malpractice litigation cases and compared with cases with adult plaintiffs. For the purposes of the analysis, plaintiff was used to describe the minor patient and any guardians who sued on behalf of the minor. Descriptive statistics were used to report our findings, and, when appropriate, the t test (MedCalc for Windows, Microsoft Excel for Windows;
Table. Pediatric Ophthalmology Malpractice Cases by Subspecialtya

<table>
<thead>
<tr>
<th>Subspecialty</th>
<th>No. (%)</th>
<th>Judgment for Plaintiff</th>
<th>Judgment for Defendant</th>
<th>No. of Payments to Plaintiffb</th>
<th>Median Payment, US $</th>
<th>Mean Payment, US $</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retina</td>
<td>15 (22.1)</td>
<td>8 (53.3)</td>
<td>7 (46.7)</td>
<td>4 (26.7)</td>
<td>12 790 465</td>
<td>17 255 077</td>
</tr>
<tr>
<td>Traumatic</td>
<td>15 (22.1)</td>
<td>8 (53.3)</td>
<td>7 (46.7)</td>
<td>6 (40)</td>
<td>714 974</td>
<td>640 823</td>
</tr>
<tr>
<td>General</td>
<td>9 (13.2)</td>
<td>4 (44.4)</td>
<td>5 (55.6)</td>
<td>4 (44.4)</td>
<td>1 672 612</td>
<td>2 358 139</td>
</tr>
<tr>
<td>Pediatric</td>
<td>8 (11.8)</td>
<td>4 (50)</td>
<td>4 (50)</td>
<td>3 (37.5)</td>
<td>1 149 386</td>
<td>880 993</td>
</tr>
<tr>
<td>Glaucoma</td>
<td>6 (8.8)</td>
<td>3 (50)</td>
<td>3 (50)</td>
<td>2 (33.3)</td>
<td>1 193 189</td>
<td>1 193 189</td>
</tr>
<tr>
<td>Oculoplastics</td>
<td>6 (8.8)</td>
<td>3 (50)</td>
<td>3 (50)</td>
<td>3 (50)</td>
<td>1 023 004</td>
<td>3 202 720</td>
</tr>
<tr>
<td>Neuro-ophthalmology</td>
<td>3 (4.4)</td>
<td>3 (100)</td>
<td>0 (0)</td>
<td>1 (33.3)</td>
<td>201 451</td>
<td>201 451</td>
</tr>
<tr>
<td>Oncology</td>
<td>3 (4.4)</td>
<td>2 (66.7)</td>
<td>1 (33.3)</td>
<td>2 (66.7)</td>
<td>670 772</td>
<td>670 772</td>
</tr>
<tr>
<td>Cornea</td>
<td>2 (2.9)</td>
<td>1 (50)</td>
<td>1 (50)</td>
<td>1 (50)</td>
<td>603 100</td>
<td>603 100</td>
</tr>
<tr>
<td>Unknown</td>
<td>1 (1.5)</td>
<td>0</td>
<td>1 (100)</td>
<td>0</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>All cases</td>
<td>68 (100)</td>
<td>36 (52.9)</td>
<td>32 (47.1)</td>
<td>26 (38.2)</td>
<td>887 310</td>
<td>3 810 824</td>
</tr>
</tbody>
</table>

Abbreviation: NA, not applicable.
a Judgment includes jury verdicts, settlements, appellate ruling, posttrial motions, and bench verdicts.
bPayments include settlements and jury awards.

Microsoft Corp) was used to compare groups. A P ≤ .05 decision rule was established a priori as the null hypothesis rejection criteria for the t test.

Results

Query of the WestLaw database for the terms ophthalmology or ophthalmologist and malpractice yielded 1261 appellate cases and 1294 jury verdicts or settlements; 1063 cases met the inclusion criteria. Sixty-eight ophthalmology malpractice cases involving plaintiffs younger than 18 years at the time of injury or inciting event were identified and included in the study, representing 6.4% of total cases. The 68 pediatric cases identified occurred between March 24, 1958, and December 31, 2014, with 61 (89.7%) of the cases occurring after 1980 (median year, 1998). Forty-four cases (64.7%) involved minor male plaintiffs. Thirty-five cases (51.5%) were resolved by means of jury trial. Of these 35 cases, 18 involved minor male plaintiffs. Thirty-five cases (51.5%) were resolved by means of jury trial. Of these 35 cases, 18 (51.4%) were associated with verdicts in favor of the defense and 17 (48.6%) resulted in verdicts in favor of the plaintiff. The mean adjusted jury award for these 17 cases was $4 815 693 (median, $883 281; range, $147 765-$42 061 690). Nine of the total 68 cases (13.2%) resulted in settlements, with mean adjusted indemnities of $1 912 738 (median, $1 377 689; range, $92 070-$8 493 086). The remaining 24 cases (35.3%) involved appellate rulings, pretrial and posttrial relief rulings, and 1 bench verdict. There was no significant difference between monetary awards associated with a jury verdict and indemnities (difference, $2 902 955; 95% CI, $2 654 558 to $8 460 468; P = .45). All cases by year, state, method of resolution, monetary award with adjustment to 2015 standard, and narrative description are found in the eTable in the Supplement. A summary of cases by subspecialty along with verdicts and indemnity payments are found in the Table.

Legal Allegation

Of the 68 cases, 39 alleged insufficient intervention on the part of the physician (eg, failure to diagnose or failure to treat). Fourteen of those 39 cases (35.9%) resulted in either a jury verdict or indemnity payments to plaintiffs totaling $77 238 525. Eleven of the 27 cases involving surgery (40.7%) resulted in payments to the plaintiffs, either via jury verdict or settlement, totaling $21 842 891. Two cases involved only medical claims, neither of which resulted in payments to the plaintiffs.

Clinical Entities

Twelve of the 68 cases (17.6%) were associated with retinopathy of prematurity (ROP). Four of these cases were resolved by jury trial, 2 in favor of the defendant and 2 in favor of the plaintiff, with adjusted awards of $23 863 008 and $42 061 690, which were the highest awards of all cases in this series. One case involving ROP resulted in a settlement of $1 717 922. All cases of ROP that were resolved in favor of the plaintiff involved allegations of failure of the defendant ophthalmologists to properly follow up with examinations for ROP in patients with whom they had an established physician-patient relationship (considered a form of nonintervention). In cases of ROP that were resolved in favor of the defendants, the courts found that either there was no established physician-patient relationship between the named defendant and the patient or that the proximate cause of the patient’s blindness could not be proven to be a result of the defendant’s negligence in the treatment of the patient’s ROP.

In 6 cases, endophthalmitis resulted in blindness; all 6 cases were resolved in favor of the plaintiffs. In 5 of these cases (83.3%), jury verdicts for the plaintiffs resulted in awards totaling $3 695 316. The sixth case was resolved via appellate ruling. Monetary awards from juries were not significantly different between cases involving endophthalmitis and those not
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Original Investigation Research

November 2016 Volume 134, Number 11

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Fifteen cases (22.1%) involved traumatic ocular injury. Mean payments were relatively low compared with other types of cases, with a mean payment to plaintiffs (settlement or indemnity) of $640,823 (difference, $4,121,001; 95% CI, −$390,921 to $8,632,923; P = .34).

Legal Blindness

Of the 68 cases, 47 (69.1%) involved patients with legal blindness in at least one eye as a result of the alleged injury. Of the 25 jury cases involving legal blindness, juries ruled in favor of the plaintiff in 14 (56%). Of the 10 jury cases that did not involve legal blindness, juries ruled in favor of the plaintiff in 3 (30%).

Pediatric vs Adult Litigation

Malpractice cases with minor plaintiffs were compared with those with adult plaintiffs. Juries were more likely to rule in favor of the plaintiff in cases involving pediatric plaintiffs (17 of 35 cases [48.6%]) than in those involving adult plaintiffs (168 of 584 cases [28.8%]) (difference, 33%; 95% CI, −24% to 64%; P = .01), and jury awards in cases with pediatric plaintiffs were higher than in cases with adult plaintiffs (difference, $3,422,134; 95% CI, −$3,422,134 to $8,731,916; P = .002). Similarly, mean indemnity payments in cases that were resolved via settlements were higher in cases with pediatric plaintiffs than in cases with adult plaintiffs (difference, $1,186,757; 95% CI, −$69,074 to $3,342,588; P = .003).

Discussion

This review of 68 ophthalmology malpractice cases involving pediatric patients is the largest study of pediatric malpractice cases in the literature, to our knowledge. It complements existing publications on the risk of litigation in the practice of all subspecialties of ophthalmology, drawing special attention to the heightened risk of awards to plaintiffs in cases involving minor patients.

Pediatric vs Adult Patients

There are many international studies on malpractice in pediatrics; however, these studies focus on patients seen in the field of pediatrics rather than on child patients seen across all medical specialties or outcomes of litigation in children’s cases compared with those involving adults.1,13 One domestic study has examined all malpractice litigation involving children across specialties using the National Practitioner Data Bank.13 Those authors reviewed all malpractice payments made on behalf of US practitioners during a 2-year period and found that 14% of the 30,195 payments issued were in cases with a pediatric plaintiff. They observed that although malpractice payments (95% of which were settlements) in cases with a pediatric plaintiff were only one-half as likely to occur than in litigation with an adult plaintiff, payments were greater in cases with a pediatric plaintiff ($422,000 vs $247,000). This study, much like ours, found that payments made in cases with a pediatric plaintiff were higher than in cases with an adult plaintiff; however, it also found that cases with a pediatric plaintiff were less likely to result in legal action than were cases with an adult plaintiff, a finding not supported in our series. It is not possible to draw any conclusions from this difference, however, because the National Practitioner Data Bank is a claims database, whereas Westlaw is a database of verdicts and settlements, and therefore does not provide information about claims.

According to a 2011 analysis of a national liability insurer covering approximately 800 ophthalmologists, less than 2% of all ophthalmology malpractice cases resulted in payment to the plaintiff, and mean payment in these cases was between $100,000 and $200,000.6 In our series, jury verdicts in favor of the plaintiff were more common with pediatric plaintiffs (48.6% vs 28.8%; P = .01). Furthermore, jury awards and settlement payments were higher with pediatric plaintiffs than with adult plaintiffs. A British study of all ophthalmology claims against the National Health Service reported that cases with a pediatric plaintiff resulted in damages totaling more than double the amount of every other subspeciality,14 which is consistent with what was observed in our series.

Overall, cases associated with failure to diagnose or treat represented 61.5% of cases resulting in either jury award or indemnity payment to plaintiffs. Cases were also more likely to be resolved in favor of the plaintiffs when the patients’ final visual acuity in the eye or eyes related to the case was less than 20/200. Jury cases involving patient blindness were more likely to be resolved in favor of the plaintiff and more likely to result in a higher monetary award. Although small sample size limits the ability to draw broader conclusions, other studies have also found that poorer visual outcome and permanence of the injury are associated with higher payments to plaintiffs.9,15,16 Cases involving patients who developed endophthalmitis were all resolved in favor of the plaintiffs; however, the amount awarded by the jury in these cases was not significantly different between cases that involved endophthalmitis and those that did not. In a study of cataract surgery claims, however, Brick15 reported that cases involving endophthalmitis were the most costly.

Although cases involving pediatric plaintiffs tended to result in more decisions for the plaintiff as well as larger monetary awards for plaintiffs than did cases involving adults plaintiffs, there were only 68 pediatric cases recorded in Westlaw during the last 84 years, which represents a small percentage of total malpractice litigation not only within ophthalmology but within medicine as a whole.
Payments
The largest payments in our analysis were issued in cases involving ROP. This series supports the findings of other studies that have found that a large proportion of litigation of cases of ROP involves failure to properly transfer care between specialists, loss to follow-up, and failure to ensure that follow-up visits and treatment are conducted within current guidelines for follow-up and treatment.9,10,17 These studies also suggested that the high risk of medical liability in caring for patients with ROP has dissuaded pediatric and retina specialists from continuing to provide treatment of ROP to these patients.9,10,17,18

Among the pediatric patients in our series, the subspecialties with the highest mean payments paid to plaintiffs were retina, oculoplastics, and general ophthalmology. The lowest payments were made in the subspecialties of neuro-ophthalmology, cornea, and trauma.

Although WestLaw provides a centralized source of information on appellate and jury verdicts that is useful for analyzing subsets of cases, the major limitations of this study are related to the limitations of the database itself. The level of detail varied, sometimes greatly, between reports of legal cases. In some cases, appellate courts overturned earlier jury decisions and granted new trials; however, in some cases, the later trial information was unavailable. In the same vein, the total amount of payments paid to plaintiffs likely underestimates the total for these cases because it does not take into account some unavailable cases with decisions reversed after the trial, and it does not include final monetary outcomes in some of the cases that were resolved for the plaintiffs. In addition, other studies of medical malpractice litigation have stated that up to 85% of malpractice litigation initiated never results in a trial.16 The result is that this analysis may overlook many out-of-court settlements with payments to plaintiffs and excludes cases that are simply dropped. Finally, our analysis is based on 68 cases, and while they represent all pediatric ophthalmology cases in WestLaw, it is a small sample size.

Rapport and Communication
Several studies have pointed to the importance of maintaining a positive physician-patient relationship as an important deterrent to litigation; however, there may be little time or opportunity to build this connection.11,19,20 In 1 study, the authors found that 45% of malpractice claims in ophthalmology occurred less than 1 month after the patient’s initial encounter with the physician and 17% occurred at the initial encounter.19 It is also important to be aware of the emotional effect that blindness or other visual disturbances have on both the patient and parents. Parental hostility toward physicians who have just delivered bad news about a medical diagnosis is a common response.21 Although lack of time is a persistent problem for busy clinicians, engaging families, particularly anxious parents, in a sympathetic dialogue about the child’s condition and expectations for the future and allowing families to ask questions may play an important role in deterring litigation. Uncertainty about a child’s illness and prognosis has been shown to be a significant stressor for parents of children with chronic or debilitating conditions.22 Specifically addressing the child’s future body image, ability to succeed in school or participate in sports, economic prospects, and parental guilt can all help to allay parents’ fears.21

Finally, many cases, especially those related to ROP, involved blindness following scheduling misunderstandings in which patients and their parents were either uninformed of the importance of returning for additional follow-up visits or were unaware that they even needed to return, a finding reported in other studies.8-10,17 These cases tended to have the largest payments to plaintiffs. Given this finding, we suggest that special care be taken when evaluating all patients, but especially pediatric patients at risk for poor outcomes, and ensuring that patients and parents truly understand their follow-up schedules and the potential consequences of noncompliance with follow-up and management.

Conclusions
In this analysis, cases tended to be resolved in favor of defendants if the defendant could prove that he or she was acting according to established practice patterns. Although this defense may seem intuitive, lack of proper and consistent documentation at the time of the patient encounter can make disproving negligence difficult.19 Managing patients’ and parents’ expectations is especially important. Understanding the possibility of negative outcomes may help patients and their families prepare for permanent changes in vision and prevent litigation.20

ARTICLE INFORMATION
Accepted for Publication: July 11, 2016.
Published Online: September 1, 2016.
doi:10.1001/jamaophthalmol.2016.3190

Author Contributions: Ms Engelhard and Dr Reddy had full access to all the data in the study and take responsibility for the integrity of the data and the accuracy of the data analysis
Study concept and design: Engelhard, Sim, Reddy
Acquisition, analysis, or interpretation of data: Engelhard, Collins, Shah, Sim
Drafting of the manuscript: Engelhard, Collins, Reddy.

Critical revision of the manuscript for important intellectual content: All authors.
Statistical analysis: Engelhard.
Obtaining funding: Engelhard.
Administrative, technical, or material support: Engelhard.
Study supervision: Engelhard, Collins, Reddy.

Conflict of Interest Disclosures: All authors have completed and submitted the ICMJE Form for Disclosure of Potential Conflicts of Interest and none were reported.

Previous Presentations: This study was presented in part at the Association for Research in Vision and Ophthalmology Annual Meeting; May 4, 2016; Seattle, Washington.

REFERENCES
Learning From Malpractice Litigation

Monte D. Mills, MD

As physicians, our first duty is to relieve pain and injury and avoid causing or worsening problems in our patients. Most of our professional training, education, and communication, including this journal, contributes to improving our patients’ health. This focus is particularly true regarding pediatric patients who are uniquely vulnerable to lifelong consequences of poor decisions. There are few accounts in the medical literature of patients who were misdiagnosed or poorly treated, or have unnecessarily complicated conditions.

The legal system, however, provides some useful data to help us understand patients who are injured in the practice of medicine, from which some meaningful conclusions may be drawn. Despite the perceived randomness and injustices of our compensation system for negligence and malpractice, including the costs of insuring against judgments, and the distortion of diagnostic and therapeutic practice to reduce the perceived risks of claims (defensive medicine), we should be able to understand and measure how and where we have not met our duty as physicians.

In this issue of JAMA Ophthalmology, Engelhard et al present an analysis of a database including all civil court verdicts, rulings, and formal court settlements in all US jurisdictions related to pediatric ophthalmology recorded for 84 years, spanning more than 2 professional generations of ophthalmologists. Significantly, this database does not contain cases settled outside of a court case, which likely represents most claims made. The authors have also not attempted to adjust the findings relative to adult malpractice judgments based on the extended discovery period available to minors in most jurisdictions.

What can be learned, based on the data presented? Perhaps most significant is the relatively low incidence of claims associated with pediatric ophthalmic patients. Despite the comprehensive nature of the database and long measurement period, only 68 cases were identified, suggesting that the risk of pediatric ophthalmic malpractice claims is relatively low. Reviewing the years of the claims studied, these data also do not support the idea that there has been a recent crisis or large increase in the frequency of legal claims in pediatric ophthalmology during the most recent decade.

As suggested in prior publications, retinopathy of prematurity appears to be an area of higher risk in pediatric ophthalmology, particularly considering the large monetary judgments involved. Also confirming previous findings, all the cases involving retinopathy of prematurity resolved in favor of the plaintiff were related to failure to appropriately follow up; close intervals between examinations and careful planning of transition from inpatient to outpatient management is critical for this infrequent but potentially devastating complication of severe prematurity.

Jury verdicts in favor of pediatric plaintiffs were both more frequent than in adult ophthalmology cases (48.6% vs 28.8%) and granted larger monetary awards, reflecting the potential lifelong burden of vision impairment to a young plaintiff. Awards were also higher in cases that involved legal blindness, which is not surprising in the context of compensation.