An Analysis of Ophthalmology Closed Claims

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A review of paid Ophthalmology claims from 2008-2016 revealed that inappropriate surgical technique and failure to diagnose were the most common allegations advanced. Often times the failure to timely diagnose was not the result of lack of clinical judgment or medical expertise, but rather, was the result of the failure to follow up on a test result, missed appointment or telephone message. Consistent systems and processes are part and parcel of practicing good medicine and are crucial to ensure continuity of care.

Inadequate documentation was noted to be present in 60% of the cases reviewed, and was the most prevalent factor contributing to the inability to defend against allegations of inappropriate technique or failure to diagnose. A case in point involved a 39-year-old patient who was referred to the defendant ophthalmologist with complaints of headaches, halos and eye pain. The only significant finding on physical exam was elevated intraocular pressure. The primary diagnosis was migraine with a secondary diagnosis of narrow angle glaucoma "by history". A follow-up visit was scheduled for 6 months. While the patient was instructed to return to the office if she experienced repeat symptoms prior to the follow-up visit, such was not clearly documented. One week prior to the scheduled follow-up visit, the patient called the office and requested an appointment due to a recurrence of the headaches. She denied any other symptoms so the nurse instructed her to keep the upcoming appointment but to call back if there were any new symptoms or if the headache worsened. Unfortunately, this telephone exchange was not documented. The patient did not keep the scheduled follow-up appointment. The physician would later testify that staff attempted to reach the patient to reschedule, but, again, such effort was not documented. Two years later, the patient self-referred to another ophthalmologist with complaints of increased vision loss and was diagnosed with angle closure glaucoma. The patient filed a lawsuit against the first ophthalmologist alleging failure to diagnose. The doctor argued that there were no objective findings at the time of the patient's initial presentation to support further testing, and that her failure to keep the follow-up appointment kept him from further treating her symptoms. While his medical judgment to follow the patient's condition rather than perform diagnostic testing at the time of the initial presentation may have been defensible, the patient's allegations that she called the office with continued symptoms but was denied an appointment, and the failure of any documented evidence of attempted follow-up of the missed appointment, worked against the physician.

Another example of woefully inadequate records compromising the defense of the case

involved a 62-year-old patient with a history of severe diabetic retinopathy and coronary artery disease who suffered a cardiac arrest during a retrobulbar anesthetic block. He was resuscitated but died a few days later from severe anoxic encephalopathy. The family of the patient sued, alleging that improper technique was used during the administration of the block. They alleged specifically that the physician failed to aspirate the needle to check for the possibility that such was placed in a blood vessel before administering the retrobulbar injection. They further alleged that this failure resulted in an intracranial injection of the Lidocaine with epinephrine, likely through the optic nerve sheath, which caused severe respiratory depression and cessation of breathing. Unfortunately, the procedure record was dictated 11 days after the adverse event and lacked the details needed to sufficiently defend the case. Specifically the record failed to indicate: (1) that any aspiration took place prior to the injection; (2) the amount of Lidocaine; (3) the details of the epinephrine mixture; and (4) the type of needle used. The family also alleged negligent resuscitative measures on the part of the physician and staff which was difficult to defend in light of the fact that no code record was completed to reflect interventions with the AED, compressions and oxygen.

Communication issues likewise played a part in the initiation of a number of the claims reviewed as well as the indefensibility. Problems with communication were identified in 29% of the claims reviewed, nearly all of which involved direct physician to patient communication breakdown. The failure of the physician to discuss material and significant risks associated with the procedure, as well as expected outcomes, oftentimes led to unrealistic expectations, patient frustration and dissatisfaction in the face of a complication. Further, the failure to document the process when it did occur left the door open for the plaintiffs to contend that they did not receive the relevant and required information and, if they had, would have sought more conservative treatment or a second opinion.

There were also instances of failing to properly educate patients on the specific risks associated with ocular medications to reduce inflammation, pressure and pain, and of what signs and symptoms would warrant a phone call or office visit.

LESSONS LEARNED:

- To promote continuity of care, implement a system to ensure abnormal test results are clearly flagged for follow-up at subsequent visits.
- Ensure you have an effective tracking method for all lab tests and diagnostic imaging. If a test or consult is important enough to order, it's important enough for staff to track and for providers to review results.
- There should be a consistent method for notifying patients of ALL test results and instructing them to call the office if they have not received the results within the expected time frame.
- There should be an established system for tracking patients who miss follow-up appointments. If a patient misses or cancels a follow-up appointment, it should be documented and investigated. Appropriate efforts should be made to contact the

patient and re-schedule the appointment in situations where the patient may suffer if treatment is delayed or where the treatment or medication must be closely monitored.

- Review the results of all tests ordered pre-operatively to ensure any abnormalities receive proper attention and follow-up.
- Document completely – including history, instructions and telephone calls as well as the rationale for actions that may not be self-evident. Such documentation not only enhances patient care, but bolsters your credibility if you are called upon to defend such care.
- Complete documentation within 24-48 hours of the office visit or procedure. Late completion of notes puts you and your colleagues at risk. Memory interferes with accuracy and efforts to "catch up" often lead to incomplete documentation. Any intervening adverse event prior to completion of notes makes late documentation appear self-serving.
- Develop scheduling policies and train staff that if the patient feels that his/her problem warrants an earlier appointment, the staff should communicate the patient's health problem to someone in the clinical department to triage for the best appointment option.
- Staff giving clinical advice should do so pursuant to an approved written protocol. The protocol should be detailed enough to include what clarifying questions the staff should ask in response to various complaints as well as when a patient should be referred to a physician.
- Clearly communicate with patients when providing medical advice over the telephone. Use the "teach back" method to ensure an understanding of the information relayed. At a minimum, the following types of phone calls should be documented in the medical record: All phone calls in which test results are reported to patients; all phone calls during which the patient is advised to return to the office or go to the emergency room; all phone calls during which the patient requests medical advice or prescription refills.
- Develop an emergency response protocol for the office outlining the roles and responsibilities of staff members in the event of a medical emergency. All clinical staff should maintain certification in Basic Life Support. Practices undertaking office-based surgery should be aware of any state guidelines regarding ACLS certification and/or required emergency equipment and supplies. Clinical staff should be trained in the use of any medical equipment maintained in the office. Mock drills should be conducted at least annually and assigned staff should routinely inventory medications and equipment for expiration dates and functionality. Additionally, designate the individual(s) who will be responsible for documenting the sequence of events during an emergency event.
- Engage in a full and clear discussion with patients about the nature of their medical condition, the recommended treatment plan and the risks, benefits, expected outcome, possibility of an additional or different procedure if indicated, and alternatives. Doing so not only discharges your legal and ethical obligation to provide patients with sufficient information with which to make an educated election about the course of their medical care, but may help create realistic expectations on

the part of the patient as to the outcome of treatment. Be careful not to educate above the patient's comprehension level. Be sure the details of all discussions with patients are documented in your office record rather than relying on hospital consent forms which are not procedure specific and may not capture all details of the conversation.

- Provide clear, detailed, understandable, procedure-specific written postoperative instructions to patients. Patients who have a clear understanding of what signs and symptoms to watch for, how medication should be administered and when to make follow-up appointments are less likely to be readmitted or visit the emergency department.

Although not present in the cases reviewed, national data reflects continued litigation stemming from a failure to warn of the risks of ambulating and operating a motor vehicle following the application of dilating drops. Physicians should engage is a clear discussion about the possible side effects associated with dilating drops such as blurry vision for 4 – 8 hours as well as sensitivity to light. Precautions about driving or operating machinery until the effects wear off and recommendations about protective eye gear should likewise be discussed and documented.
