Prevention of Medical Errors

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DISCLOSURE

Dr. Joseph Sowka, within the past 12 months, is/has been a member of the advisory boards for Visus, Zeiss, and B&L. Dr. Sowka has no direct financial interest in any of the diseases, products or instrumentation mentioned in this presentation. He is a co-owner of Optometric Education Consultants.
www.optometricedu.com

Purpose of Course

- To reduce risk of medical errors occurring in optometrists' offices
- To improve patient safety
- As of May 8, 2002 a new rule has been added to 64B13-5.001 (8). Licensees are required to complete a 2-hour course relating to prevention of medical errors as part of the licensure and renewal process

Purpose of Course

- The Florida State legislature mandated that all licensees must complete a two-hour course on prevention of medical errors
- The 2-hour course shall count towards the total number of continuing education hours required for the profession.
- Shall include a study of root cause analysis, error reduction and prevention, and patient safety

Why we are really doing this?


String of Errors Put Florida Hospital on the Critical List
April 14, 1995 | MIKE CLARY | SPECIAL TO THE TIMES

TAMPA -- Diabetic and disabled, 52-year-old Willie King seems an unlikely figurehead for a national uprising over patients' rights. Two months ago, the retired heavy-equipment operator checked into University Community Hospital here to have his diseased right leg amputated. A doctor cut off his left leg instead.

"When I came to and discovered I lost my good one, it was a shock, a real shock," King said in a press conference three weeks after the Feb. 20 operation. "I told him: 'Doctor, that's the wrong leg.'"

Dr. Sanchez testified that he learned of his error from a nurse as he was still cutting through the leg of the patient, Willie King, 52. After reviewing the patient's file, she had started to shake and cry. But by that point, he said, there was no turning back. "I tried to recover from the sinking feeling I had," he testified, as his eyes grew moist and his voice trailed off.

Epidemiology

- November 1999, the IOM revealed a hidden epidemic in the United States:
- Medical errors result in injury to 1 in every 25 hospital patients and an estimated 44,000 to 98,000 deaths each year. Even the lower estimate makes medical errors more deadly than breast cancer (42,297), motor vehicle accidents (43,458) or AIDS (16,516).
- ("To Err Is Human: Building A Safer Health System." Institute of Medicine. December 1999.)

Epidemiology

- Medical errors cost the economy from $17 to $29 billion each year.
- Agency for Healthcare Research and Quality (AHRQ) has shown that medical errors result most frequently from systems errors-organization of health care and how resources are provided in the delivery system.
  - Only rarely are medical errors the result of carelessness or misconduct of a single individual.

Epidemiology

- Medication errors are thought to cause 7,000 deaths annually – more than the 6,000 deaths that occur each year in the workplace. The annual cost of medication errors is at least $2 billion

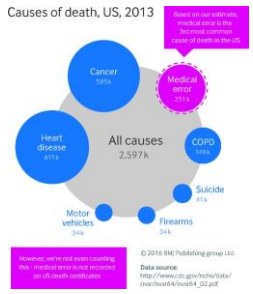
Epidemiology

- IOM reported only hospital errors
- Many errors occur outside the hospital.
- In an investigation of pharmacists, the Massachusetts State Board of Registration in Pharmacy estimated that 2.4 million prescriptions are filled improperly each year in the State

- 1999 IOM report underestimates the magnitude of the problem
- A 2004 report of inpatient deaths associated with the Agency for Healthcare Quality and Research Patient Safety Indicators in the Medicare population estimated that 575 000 deaths were caused by medical error between 2000 and 2002, which is about 195 000 deaths a year

- In 2008, 180 000 reported deaths due to medical error a year among Medicare beneficiaries alone.
- Classen et al described a rate of 1.13%. If this rate is applied to all registered US hospital admissions in 2013 it translates to over 400 000 deaths a year, more than four times the IOM estimate.

*Classen D, Resar R, Griffin F, et al. Global "trigger tool" shows that adverse events in hospitals may be ten times greater than previously measured. Health Aff2011;**30**:581-9*



Types of Medical Errors

- The IOM report defines an error as:
  - The failure of a planned action to be completed as intended (i.e., error of execution)
    - Tobrex instead of Tobradex
  - The use of a wrong plan to achieve an aim (i.e., error of planning).
    - NSAID or weak steroid on raging uveitis
    - Tobradex on dendritic or fungal keratitis

Types of Medical Errors

- An adverse event is an injury caused by medical management rather than the underlying condition of the patient (e.g. allergic response to a drug). An adverse event attributable to error is a preventable adverse event, also called a sentinel event, because it signals the need to ask why the error occurred and make changes in the system (prescribing drug to which patient is allergic because you didn't ask).

Why Errors Happen

- Active Errors: Active errors occur at the level of the frontline operator, and their effects are felt almost immediately.
- Latent errors: Latent errors tend to be removed from the direct control of the operator and include things such as poor design, incorrect installation, faulty maintenance, bad management decisions, and poorly structured organizations.

Latent Error – Sentinel Event

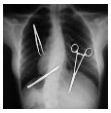
- High volume LASIK surgery
- Patient experiences acute anxiety and backs out on morning of surgery
- Patient data never removed from lineup
- Next patient undergoes LASIK with information from departed patient
- Four diopter myope now nine diopter hyperope

Latent Error – Sentinel Event

- Pt develops CN III palsy from aneurysm
  - Treatment choices: aneurysm clip or endovascular coil packing
- Successfully treated with aneurysm clip
  - All coils are inert and MRI safe; not all clips are MRI safe
- Radiologic tech doesn't verify type of clip
- Pt undergoes F/U MRI with non-MRI safe clip in major medical center
- Clip displaces during MRI
- Patient has fatal hemorrhage during procedure
- Patient survived disease…but not the treatment

Top 10 Sentinel Events- 2013*

1. Wrong-patient, wrong-site, wrong-procedure — 60
2. Unintended retention of a foreign body — 56
3. Delay in treatment — 56
4. Fall — 48
5. "Other" unanticipated event (includes unexpected additional care/extended care, and psychological impact) — 40
6. Op/postop complication — 37
7. Suicide — 35
8. Criminal event — 26
9. Medication error — 20
10. Perinatal death/injury — 15



Top 10 Sentinel Events- 2014*

1. Unintended retention of a foreign body — 57
2. "Other" unanticipated event — 53
3. Fall — 44
4. Suicide — 39
5. Wrong-patient, wrong-site, wrong-procedure — 35
6. Delay in treatment — 34
7. Criminal event — 29
8. Op/postop complication — 27
9. Perinatal death/injury — 17
10. Medication error — 12

Joint Commission, 2014

Surgeon fined $3K for removing kidney he thought was tumor

WELLINGTON, Fla. — The Florida Board of Medicine says a West Palm Beach surgeon has agreed to pay a $3,000 fine for removing a woman's healthy kidney that he thought was a tumor.

The Palm Beach Post reports Ramon Vazquez was responsible for cutting Maureen Pacheco open in 2016 so two other surgeons could perform a back operation.

Pacheco had a kidney that never ascended into her abdomen, and Vazquez believed it was a cancerous tumor near her pelvis and removed it without her consent. Vazquez has said that he didn't review her medical records before the surgery.

Conditions that Create Errors

- Any given precondition can contribute to a large number of unsafe acts
  - training deficiencies can show up as high workload
  - undue time pressure
  - inappropriate perception of hazards
  - motivational difficulties
- Preconditions are latent failures embedded in the system

Surgical Errors

- Surgical adverse events accounted for two-thirds of all adverse events and 1 of 8 hospital deaths
- Wrong-site surgery was most common in orthopedic procedures. Risk factors contributing to the error included more than one surgeon involved in the case, multiple procedures performed during a single operating room visit, and unusual time pressures, particularly pressure to speed up preoperative procedures

Diagnostic Inaccuracies

- Incorrect diagnoses may lead to incorrect and ineffective treatment or unnecessary testing.
- Inexperience with a technically difficult diagnostic procedure can affect the accuracy of the results.
  - Study that demonstrated that measuring blood pressure with the most commonly used type of equipment often gives incorrect readings that may lead to mismanagement of hypertension.

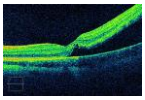
Diagnostic Inaccuracies

- Types of Diagnostic Error
  - Misdiagnosis leading to an incorrect choice of therapy (Steroid Combo med on a dendritic or fungal keratitis)
  - Failure to use or order an indicated diagnostic test (VF, CV, eye not correctable to 20/20)
  - Misinterpretation of test results
  - Failure to act on abnormal results

Snatching defeat out of the jaws of victory

- Pt presents with reduced acuity (20/50)
- OD diagnoses CSC based upon OCT
  - Doesn't dilate to confirm
- Case goes to trial- OD prevails
  - Poor expert witness for plaintiff
- Verdict gets overturned on appeal
  - Technicality
- Goes back into litigation

Representative image



If you are going to use technology, please interpret results correctly

Failure to order the proper test or referral

- Thursday: 58 YOM with vision loss OD: Dx AION OD > OS; mild headache and pharyngitis
  - Recommended: OCT (ordered), ESR, CRP, platelets (not ordered)
- Friday: OCT performed
- Saturday: OCT interpreted- disc swelling OD > OS
  - CTJ moment; fax to PCP for serology "ASAP". Office not open
- Sunday: Bupkis
- Monday: message read
  - Serology and carotid testing set for Wednesday evening
- Tuesday: pt wakes up with profound vision loss OS
  - Walks into ER and gets tests done- everything elevated
  - Dx: temporal arteritis- legally blind

System Failures

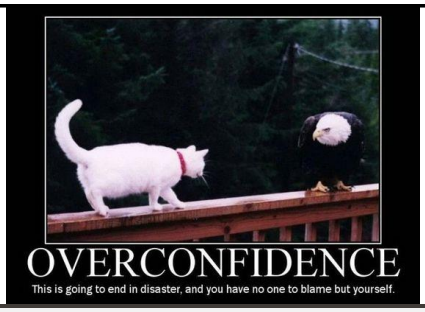
- Although errors in medication, surgery, and diagnosis are the easiest to detect, medical errors may result more frequently from the organization of healthcare delivery and the way that resources are provided to the delivery system. (Latent errors)
  - Emergencies turned away by appointment desk

Conditions that Create Errors

- Precursors or Preconditions
  - A need to have the right equipment, well-maintained and reliable
  - A skilled and knowledgeable workforce
  - Reasonable work schedules
  - Well-designed jobs
  - Clear guidance on desired and undesired performance
- Preconditions are latent failures embedded in the system

Factors and Situations That Increase the Risk of Errors

- Fatigue
- Alcohol and/or other Drugs
- Illness
- Inattention/Distraction
- Emotional States
- Unfamiliar Situations
- Communication Problems
- Illegible Handwriting



Medication Errors

- Problems related to the use of pharmaceutical drugs account for nearly 10 percent of all hospital admissions, and significantly contribute to increased morbidity and mortality in the United States (Bates. 1995).

Six Rights

- Right Patient
- Right Drug
- Right Dose
- Right Dosage Form
- Right Route
- Right Time

Top 10 Medication Errors

1. Sound-a-like Drugs
2. Lack of Drug Knowledge
3. Dose Calculation Errors
4. Decimal Point Misplacement
5. Wrong Dosage Form
6. Wrong Dosage Frequency
7. Use of Abbreviations
8. Drug Interactions
9. Renal Insufficiency
10. Incomplete Patient History

Medication Errors

- In a study of inpatient care in two tertiary care hospitals, errors in ordering and administering medications accounted for 34-56 percent of preventable adverse drug events.
- A follow-up study showed that dosage errors, in particular, were primarily due to the physician's lack of knowledge about the drug or about the patient for whom it was prescribed.

Sound-a-Like Meds

- **Vexol (rimexolone) Ophthalmic drops**

Vs.

- **Vosol (acetic acid) Otic drops**

Sound-a-Like Meds

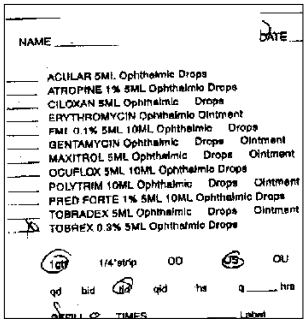
- Tobrex (tobramycin) Ophthalmic drops

Vs.

- Tobradex (tobramycin and dexamethasone) Ophthalmic drops

Case

- A pediatric ophthalmologist prescribed TOBREX (tobramycin) 0.3% ophthalmic drops for a one-month-old infant with a dacryocystitis (one drop TID to the left eye). The physician indicated this drug by checking off a space on a preprinted prescription order form which listed 12 different ophthalmic drops including TOBRADEX (tobramycin and dexamethasone) which appeared on the line above Tobrex.



NAME _____ DATE _____

_____ ACULAR 5ML Ophthalmic Drops
_____ ATROPINE 1% 5ML Ophthalmic Drops
_____ CILOXAN 5ML Ophthalmic Drops
_____ ERYTHROMYCIN Ophthalmic Ointment
_____ FML 0.1% 5ML 10ML Ophthalmic Drops
_____ GENTAMYCIN Ophthalmic Drops Ointment
_____ MAXITROL 5ML Ophthalmic Drops Ointment
_____ OCUFLOX 5ML 10ML Ophthalmic Drops
_____ POLYTRIM 10ML Ophthalmic Drops Ointment
_____ PRED FORTE 1% 5ML 10ML Ophthalmic Drops
_____ TOBRADEX 5ML Ophthalmic Drops Ointment
_____ TOBREX 0.3% 5ML Ophthalmic Drops

1gtt 1/4"strip OD OS OU

qd bid tid qid hs q ____ hrs

APPLY TIMES _____ Label

Same Drug – Different Direction

- Prescribed Tobradex
- Patient fails to improve
- Produces bottle of Tobrex
- Whose mistake? Doctor? Pharmacy? Company?
- Ask to see medications at follow-up

Tobradex again?!

- Pt diagnosed with infectious keratitis
- Doctor prescribes tobrex and gatifloxacin
- Techs E-prescribe in office
  - Tobrex not in system, but Tobradex is…
  - Tech assumes they are the same- never asks doctor
- Pt has fungal keratitis…

Sound-a-Like Meds

- Zymar (gatifloxacin) Ophthalmic drops

Vs.

- Zymase (amylase, lipase, protease) capsules for digestion

Sound-a-Like Meds

- Ocuflox (ofloxacin 0.3%) Ophthalmic drops (Allergan)

Vs.

- Ocufen (flurbiprofen 0.03%) Ophthalmic drops (Allergan)

Sound-a-Like Meds

- Vesneo Vs. Visine
- Vyzulta Vs. Cymbalta

Sound-a-Like Meds

- U.S. outpatient pharmacies filled 3.9 billion prescriptions in 2009, according to most recent figures from Wolters Kluwer Pharma Solutions. Overall, the dispensing error rate is 1.7 percent, which translates into more than 66 million drug mistakes a year.

Sound-a-Like Meds

VitA-POS (ocular lubricant)

Vs.

Vitaros (erectile dysfunction cream)

- Due to a doctor's illegible handwriting, a woman in Scotland who was prescribed the ocular lubricant VitA-POS was given the erectile dysfunction cream Vitaros instead. The patients suffered eye pain, blurry vision, redness, and yes—swelling. The dispensing pharmacist didn't stop to question why an erectile dysfunction drug was prescribed to a woman, which should have at least given him a reason to double check.

Sound-a-Like Meds

Takeda agreed to change the name of its new heartburn drug Kapidex after reports of confusion with the prostate cancer drug Casodex. In some cases, women received a cancer drug intended only for men.

Vs.

SOUND-A-LIKE MEDS

AcetaZOLAMIDE (Diamox) Vs.

AcetoHEXAMIDE (Dymelor)

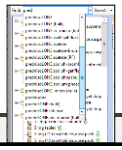
Type 2 diabetes treatment

Sound-a-Like Meds

- Most often involved in look-alike, sound-alike errors?
  - Pharmacy technicians: 38%
  - Pharmacists: 24%
  - Registered nurses: 20% percent
  - Physicians: 7%

Med Module Changes

- Effort to use a combination of upper- and lower-case letters to differentiate drugs, called "**Tall Man lettering**"
- Using that system, the potentially confusable drugs "prednisone" and "prednisolone" would be written as "**predniSONE**" and "**prednisoLONE**" to tell them apart



Sound-a-Like Meds

- Refresh Liquigel

Vs.

- RePhresh Vaginal Gel

Computerized Drug Ordering

- A physician selected OCCLUSAL-HP (17% salicylic acid for wart removal) instead of OCUFLOX (ophthalmic ofloxacin) from a alphabetical product list in a computerized prescriber order entry system and sent the prescription to a hospital outpatient pharmacy with directions to "use daily as directed."

Look-a-Like Packaging

- *The problem of packaging similarities with ophthalmic medications is related in part to FDA approval of a color-coding system by pharmacologic class, making all products within a class the same color.*

Look-a-Like Packaging

- Sulfacetamide, Tobramycin, Neomycin, Ocufloxacin

Look-a-Like Meds

- Dexacidin vs. Vasocidin

Look-a-Like Meds

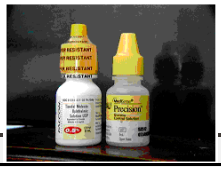
- B&L Products

Look-a-Like Packaging

- Generics are no different

Look-a-Like Meds

- Precision Glucose Control Soln vs. Timolol



Look-a-Like Packaging

- Ophthalmic

Vs.

- Otic

Look-a-Like Packaging

- Ophthalmic

Vs.

- Otic

Look-a-Like Packaging

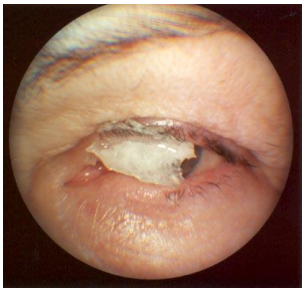
- FML Forte

Vs.

- Pred Forte

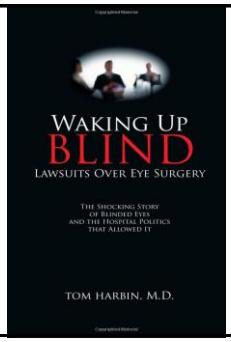
Look-a-Like Packaging

- ALREX vs. NAIL GLUE



Practice Recommendations

- Special care to Sound-a-like and Look-a-Like Medications
- Avoid pre-printed prescription pads if possible
- Have patient bring all medications that you've prescribed with them
- Patient Education



Waking Up Blind is the story of how an eye surgeon became the cause of an array of medical problems for his patients. It is also the story of how one of the nation's premier medical centers tried to conceal the growing scandal. The faculty who exposed the problems were punished. Official committees and the university leaders minimized the misconduct. Slowly, lawsuits and publicity brought some to light in bits and pieces.

Error Prevention

- Identification and Evaluation of Error
- Hospital Mortality and Morbidity Meetings
  - Recourse free error reporting protocol
- Automated Equipment
  - Recall system
  - Medication ordering systems/software
- Professional Continuing Education

Doctor-Patient Communication

- Know all your patient's medications, vitamins and herbs
- Question about allergies and past adverse reactions to medications
- Write prescriptions legibly so patients and pharmacists can read them

Florida Prescriber Law

- Florida Statute 456.42 A written prescription for a medicinal drug issued by a healthcare practitioner licensed by law to prescribe such drug must be legibly printed or typed so as to be capable of being understood by the pharmacist filling the prescription; must contain the name of the prescribing practitioner, the name and strength of the drug prescribed, the quantity of the drug prescribed in both textual and numerical formats, and the directions for use of the drugs; must be dated with the month written out in textual letters; and must be signed by the prescribing practitioner on the day when issued.

Patient Education

- Pharmacists are our allies
- What is the medicine for?
- How is it supposed to be taken?
- What side effects are likely?
- What to do if side effects occur?
- Drug interactions?
- What food, drink or activity should be avoided or included?
- Have patient check meds from pharmacy
- Which generics are not acceptable
- Encourage Patient's questions

Professional Communication

- Inter and Intra professional communication
- Communicate with patient's other healthcare providers to coordinate care.

Root-Cause Analysis

- Understanding Why Errors happen
- JCAHO requires that a thorough, credible RCA be performed for each reported sentinel event.
  - What Happened?
  - Why did it happen?
  - What do you do to prevent it from happening again?

Root-Cause Analysis

- Includes experts from all services involved
- Those who are most familiar with situation
- Asking WHY at each level of cause and effect
- Identification of changes needed
- As great a degree of impartiality as possible
- Ultimately, Root cause analysis is a tool for identifying prevention strategies.
- It is a process that is part of the effort to build a culture of safety and move beyond the culture of blame.

Patient Safety

- Stress dose adjustment in children and elderly patients
- Limit Access to high hazard drugs
- Use protocols for high hazard drugs
- Computerized drug order entry
- Use pharmacy-based IV and drug mixing programs
- Standardize drug packaging, labeling, storage
- Use "unit dose" drug systems (packaged and labeled in standard patient doses)
  - Medrol dose pack; Z-Pak

Patient/Office Safety

- Standards for Healthcare Professionals
- Licensing, Certification and Accreditation
- Role of Professional Societies
- Infection Prevention
  - Tonometer tip, gonioprism, etc.
- OSHA
- CPR/EMS
- Handling common medical emergencies
  - Vasovagal Syncope

Reducing Medical Errors within the Optometric Practice

Malpractice and How it Happens – a Look at Some Cases

Malpractice

- A dereliction of professional duty or a failure to exercise an ordinary degree of professional skill or learning by one (such as a physician) rendering professional services which results in injury, loss, or damage.
- An injurious, negligent, or improper practice

Role of the Expert Witness

- Handle an adversarial situation
- Be fair and objective
- Be balanced
- Educate
- Optometry vs ophthalmology

Three Main Offenders

- Failure to detect retinal detachment
- Failure to detect glaucoma
- Failure to detect tumor

In Other Words…

- Failure to listen to the patient
- Failure to observe the signs
- Failure to make the diagnosis fit the findings
  - Not vice-versa
- Failure to do the appropriate tests and follow-up
- Failure to make the proper referral
- Making a diagnosis of exclusion the first diagnosis instead of the last

Failure to Listen to the Patient

- Failure to do the appropriate tests and follow-up
- Failure to make the proper referral

Failure to Observe the Signs

- A 16-year-old male presents for contact lens fitting.
- His refraction is: +1.00 - 1.00 x 180 - 20/40
  +0.75 - 0.50 x 005 - 20/20
- Fundus – "WNL"; no c/d ratio
- He is diagnosed with refractive amblyopia OD and fit with contact lenses.
- At 2-week f/u, his VA is 20/100 OD – "good fit" recorded.

Failure to Observe the Signs

- One month f/u – 20/200 OD – "good fit"
- Discharged
- Annual exam:
  - Refraction unchanged – 20/400 OD, 20/20 OS
  - Fundus WNL
  - New lenses ordered
- Contact lens dispense – "Right lens not clear"
  - Retinal detachment OD
- Recommendation: Seek settlement

Failure to Diagnose Retinal Detachment

- 50 YOWM
- Sees flashes and floaters
- Presents to optometrist
- Dilation and BIO performed
  - "Ø breaks, Ø detachment" recorded
- Patient warned signs and symptoms RD
- Dismissed

Failure to Diagnose Retinal Detachment

- Patient has worsening of symptoms and vision loss one week later
- Telephones optometrist who immediately directs patient to retinal specialist
  - Does not record this in the chart
- Patient now has RD
- Poor surgical outcome
- Sues OD for malpractice
- Is it malpractice? Was standard of care breached?

Failure to Diagnose Retinal Detachment

- Could OD have missed existing break?
- Could break have been undetectable to best retinal specialist?
- Could there have been no break initially and one formed after exam?
- Bad outcome yes – malpractice no

Failure to Diagnose Retinal Detachment

- Plaintiff attorney: "I have another optometrist that will swear that this is malpractice."
- Me: "Well, you better give him a call because I'm not doing it!"
- Plaintiff attorney: Even for $$?"
- Me: "No!"

Failure to Diagnose Retinal Detachment

- Treating retinal specialist deposed
- Plaintiff attorney: "Could Dr. XYZ have missed the retinal break?"
- Retinal specialist : "Well, yes. It is likely he did. He is not a physician, you know".

Legal Pot of Gold

Legal Pot of Gold

- Treating ophthalmologist opining on OD who allegedly missed angle closure.
- OD sued for infectious keratitis- is friendly with corneal specialist and recommends him as expert witness.

Another Retina Specialist Perspective

Q. *"Do you think that you as a medical doctor, as an ophthalmologist are better trained and equipped to rule out or rule in a retinal detachment than an optometrist? '"*

A. *"I think optometrists are trained or supposedly are trained in their field to be able to do a dilated fundus exam to diagnose retinal tears or detachments as well as any other eye care professionals. "*

Q. *"You believe an optometrist has the same expertise and ability to diagnose a retinal detachment or retinal tear as you do? "*

A. *"Setting my ego aside, I would say that optometrists are trained to evaluate the peripheral retina as well as an ophthalmologist and that's my answer. "*

Sometimes it is Black and White… or Worse

- 55 YOBM with 'weed whacker abrasion'
  - 2 ODs
  - Shallow chamber; IOP < 5 mm; hypopyon
  - End Result?

"Standard of Care?"

- *"In all medical probability, the retinal break/ corneal perforation/ whatever-it-may be was present at the time of your examination and because you failed to see and diagnose it, you fell below the standard of care. Because the standard of care dictates that you would have seen and diagnosed it. And because you didn't, you were negligent".*

Standard of Care and Negligence

- Negligence refers to a person's failure to follow a duty of conduct imposed by law.
- Every health care provider is under a duty to:
- use his/her best judgment in the treatment and care of his/her patient;
- to use reasonable care and diligence in the application of his/her knowledge and skill to his/her patient's care;
- to provide health care in accordance with the standards of practice among members of the same health care profession with similar training and experience situated in the same or similar communities at the time the health care is rendered

Highest Degree of Skill Not Required

- The law does not require of a health care provider absolute accuracy, either in his/her practice or in his judgment. It does not hold him/her to a standard of infallibility, nor does it require of him/her the utmost degree of skill and learning known only to a few in his profession. The law only requires a health care provider to have used those standards of practice exercised by members of the same health care profession with similar training and experience situated in the same or similar communities at the time the health care is rendered

Not Guarantor of Diagnosis, Analysis, Judgment or Result

- A health care provider does not, ordinarily, guarantee the correctness of his/her diagnosis, analysis, judgment as to the nature of a patient's condition or the success of his/her health care service rendered.
- Absent such guarantee, a health care provider is not responsible for a mistake in his/her diagnosis, analysis, judgment unless he has violated the duty (one or more of the duties) previously described.

Bad Outcome vs Malpractice

- 60 YOBF
- Routine exam with OD
- IOP: Upper 40's OU
- Glaucoma suspect
- Begins topical treatment
- Manages for 2 years
- IOP low to mid 20's

Bad Outcome vs Malpractice

- Seeks care from ophthalmologist
- On multiple meds
- IOP mid 20's
- Meds changed
- IOP low 20's
- Undergoes ALTP, then trabeculectomy OU
- Sues optometrist
- Retained by patient's attorney

Bad Outcome vs Malpractice

- Allegations:
- Detected elevated IOP and *only* used topical medications
- Diagnosed glaucoma, but failed to warn of serious nature
- Failed to diagnose optic nerve injury
- Failed to properly treat optic nerve injury
- Failed to refer to ophthalmologist

Bad Outcome vs Malpractice

- Files:
- Medications obviously added, notations unclear
- No C/D ratio recorded for 1 ½ yrs
- Dilated exam performed, nothing recorded
- No gonio recorded
- No fields
- Frame style, bifocal style, seg height, PD, temple length, A/R coating, tint, all charges recorded
- Is this malpractice? Are allegations accurate?

Sometimes you JUST shake your head

- Retained for defense
- Diabetic pt sees OD who diagnosis PDR OU
- Educates and warns risk permanent blindness- must see retinal specialist w/i 7 days
- Pt sees another OD 6 weeks later
- Detailed exam completely normal
- Pt now completely visually impaired from PDR

Sometimes you JUST shake your head- Part ii

- Defending OD alleged to have misdiagnosed PXG
- Affidavit- *"There was no evidence of glaucoma at this time"*

A Festival of Ignorance

- 37 YOF- pterygium surgery. PF post-op
- Sees OD 3 weeks p/o. Some blur
  - No IOP
- Sees another OD next day
  - Dilates; swollen nerve, refers, no IOP
- Sees retinal specialist same day
  - IOP 49.5 mm Hg
  - Injects steroid
- All 3 sued for missing steroid induced glaucoma
- Does any glaucoma cause a swollen nerve?

A Festival of Ignorance

- Plaintiff's expert witness:
- *"Pallor is common in glaucoma"*
- *"This case had extremely fast progression of the field loss"*
- *"Glaucoma commonly occurs with minimal cupping"*
- *"Extremely high intraocular pressure commonly causes a swollen nerve"*
- *"You never consider ischemic neuropathy in a patient under 70 years"*

A Festival of Ignorance: Part II

- 55 YOF; cerebral palsy; poorly communicative; some discomfort OS
  - *NLP OD; 20/200 OS; -13.00 DS OU*
  - *Treated at ER for abrasion; OD sees no abrasion in consult*
    - *Refers to ophthalmologist- never goes*
- *Caregiver perceives worsening visual function- goes back to ER: IOP 38 mm OS- Dx: angle closure*
  - *Airlifted to another hospital ($38,000)*
  - *On call ophthalmologist won't go in (January 1)*
  - *Phones in Diamox, timolol, pilocarpine*
- *Pt has uveitis*
- *Numerous condemnations again OD by expert witness*
  - *Needed to dilate; uveitis not blinding; IOP of 38 immediately blinding*

Surviving the Legal Process

The Most Important Thing to Remember

It isn't personal…it's just business

Am I Being Sued?

- Subpoena for your records
  - Most likely not being sued
    - Accidents, disability, etc.
  - Send immediately
    - 10-day window
    - Make sure records complete…and unaltered
- Notice of Intent to Litigate
  - Now you are being sued

Notice of Intent to Litigate

- Notice immediately tries to beat you into submission.
- Doesn't mention your care or your exam, but your *negligence*
  - "Prior to your *negligence*…", "As a result of your *negligence*…", "Was there anything subsequent to your *negligence*…"
- DO NOT respond to this yourself
  - Contact insurance company- get attorney

It All Lies in the Depositions

- Attorneys representing all parties involved
- Court reporter/ videographer
- No judge or jury
- Fact finding mission
- Don't volunteer information
  - Won't convince them they were wrong to file suit – cases aren't won in deposition, but they are lost
- Insist on home field advantage

It All Lies in the Depositions

- Trial is nothing more than a performance
  - Written
  - Rehearsed
  - Hair and makeup
  - Jury is the audience
  - No smoking guns
  - Everything comes from the depositions
    - The "Script"

Just answer the question

- You have to answer unless instructed not
  - Your attorney will object throughout- still answer
- Don't try to educate plaintiff's attorney
  - Could give beneficial information not otherwise asked
- Avoid temptation to give "great" testimony
  - You'll have your chance in court
- Be prepared and be professional

Beware wolves in sheep's clothing

- Deposition is adversarial
- Some attorneys will intimidate, others will kill with kindness
  - He/she is the enemy
  - Wants information to use against you
  - Always keep up your guard
- Get comfortable with attorney – agree to something medically ridiculous
- If tired – take a break

Look in the mirror

- Appearance and demeanor as important as testimony*
  - Be neat
  - Avoid anger, hostility, condescension*
    - *"ODs are just failed physician wannabes"*
      - 172 medical schools; just 23 optometry colleges
- Questions phrased to make you appear dishonest*
  - Keep concentration and composure
  - Attorney may become intimidated by your resilience

*It's not personal…it's just business

Know what you are answering

- Attorney is not medical professional
  - May ask confusing questions
  - Ask for question to be repeated or rephrased
- Don't be intimidated into answers the attorney wants
  - Very few absolutes in life
- You must answer 'yes' or 'no'
  - You can explain yourself <u>after</u> answering
    - Not before- becomes adversarial

Red flags

- "Would you agree that…"; "Is it a fair statement…"
  - Typically precede proposition that is too broad to be answered by yes or no.
- These questions are fashioned to elicit material to use against you.
- Think before you speak

One at a time

- Let attorney finish question before answering
  - Understand question before responding
  - Court reporter can only transcribe so fast
    - Complete question won't be in transcript
  - Your attorney has time to voice objections
- Be sure that entire question is accurate before saying yes
  - If any portion inaccurate or illogical – say no

Sometimes you cannot remember

- Facts occurred several years ago
  - Refer to records during questioning
- What about questions with no recollection or records?
  - If you remember – say so
  - If you don't remember – say so
  - Don't guess or <u>speculate</u>

Watch what you are answering

- Hypothetical questions are posed only to be used against you
- Sometimes a hypothetical question cannot be answered
- Make sure that you agree with entire hypothetical before answering
- No rule that you must have opinion on hypothetical

- It is not a crime to meet with your attorney
  - May try to intimidate
- Nothing is off the record
  - Keep your mouth shut
- Tell the truth
  - There are very few cases that can't be defended on the facts
  - There are very few cases that can be defended if the defendant is caught lying.

Hold to your opinion

- Attorney will try to imply that you are lying
  - Hold firm to your opinion
- If attorney doesn't like your answer, he/she will repeat with prefaces " Are you telling us under oath…" or "Is it really your sworn testimony that…"
  - Don't be intimidated
  - Your answer is your answer; if asked repeatedly, repeatedly give the same answer
    - Rope-a-dope

Prepare

- Read! Read! Read!
- Skilled attorney can get competent physicians to agree to medical impossibilities
- Once something is said in deposition, it is written in stone.
- You will always have a chance to explain yourself in a court of law.
- You can defend virtually anything

In Conclusion…

- Risk of malpractice is a fact of professional life
- You *will* get through it
- It will not end your life, practice, career
- It's not personal…it's just business.