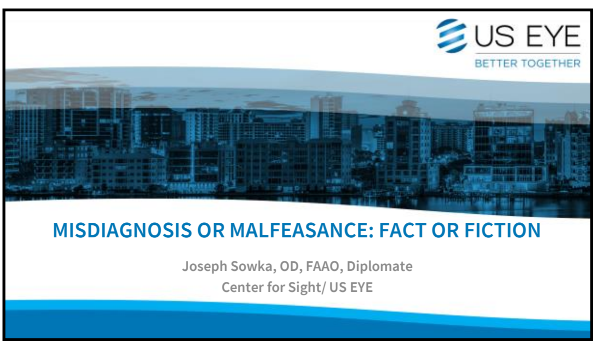
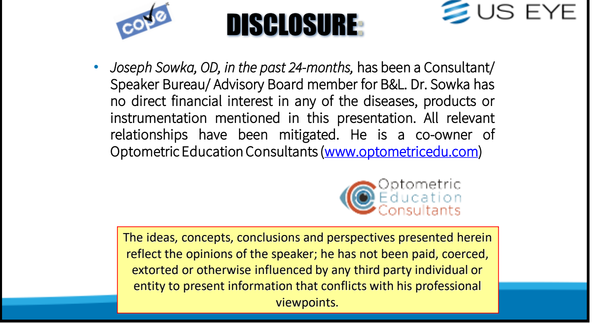

US EYE
BETTER TOGETHER
MISDIAGNOSIS OR MALFEASANCE: FACT OR FICTION
Joseph Sowka, OD, FAAO, Diplomate
Center for Sight/ US EYE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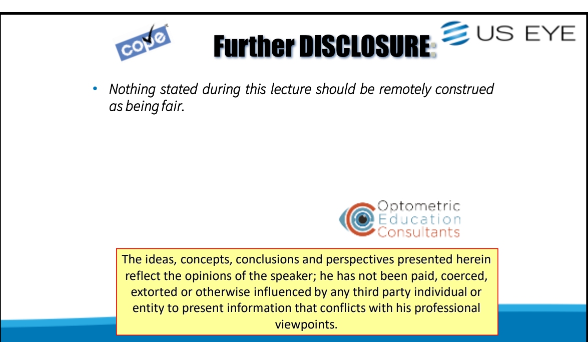
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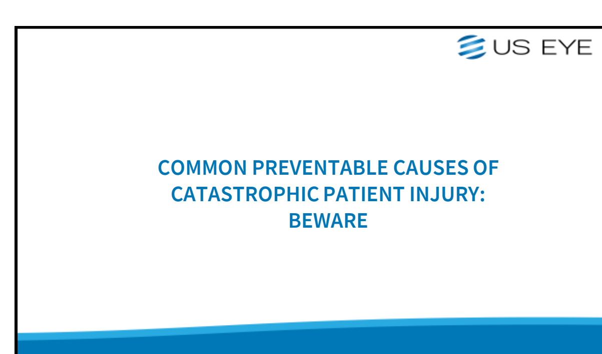
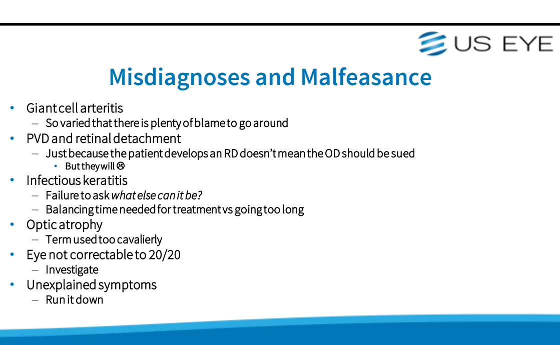
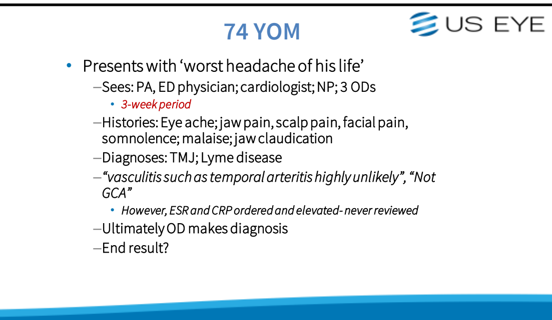

US EYE
COMMON PREVENTABLE CAUSES OF CATASTROPHIC PATIENT INJURY: BEWARE


US EYE
Misdiagnoses and Malfeasance
Giant cell arteritis
So varied that there is plenty of blame to go around
PVD and retinal detachment
Just because the patient develops an RD doesn't mean the OD should be sued
But they will ☹
Infectious keratitis
Failure to ask what else can it be?
Balancing time needed for treatment vs going too long
Optic atrophy
Term used too cavalierly
Eye not correctable to 20/20
Investigate
Unexplained symptoms
Run it down


74 YOM
US EYE
Presents with 'worst headache of his life'
Sees: PA, ED physician; cardiologist; NP; 3 ODs
3-week period
Histories: Eye ache; jaw pain, scalp pain, facial pain, somnolence; malaise; jaw claudication
Diagnoses: TMJ; Lyme disease
"vasculitis such as temporal arteritis highly unlikely", "Not GCA"
However, ESR and CRP ordered and elevated- never reviewed
Ultimately OD makes diagnosis
End result?

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
  - CTL moment; fax to PCP for serology "ASAP". Office not open
- Sunday: Nothing
- 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

72 YOF

- Presents with 6 week hx. of scalp pain, fatigue, weight loss, TVL/TIA OD.
- Presents to optometrist with sudden vision loss OD
- Findings: OD NLP; OS 20/20
- Diagnosis: "papilledema" OD. Plan: refer to ophthalmologist next day
- Presents to ophthalmologist: NLP OD; NLP OS
- Diagnosis: bilateral AAION

68 YOF

- 1 mos hx. sore throat, cough, ear pain: no response to antibiotics
- Lost vision OD
- Neurologist: OD Horner's syndrome
- Ophthalmologist: OD CRAO
- Treatment/ work-up: NONE

Case Continued

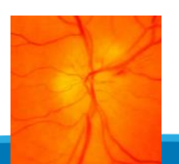
- 1 month later: sudden vision loss in fellow eye (OS)
- Hx: not eating for 6 wks prior to initial visit due to pain while chewing
- OS: NLP; AION, pupil-involved CN III, hypotony; OD Horner's, CRAO
- ESR: 114; (+) Tab
- Steroids: symptoms abated, no visual recovery

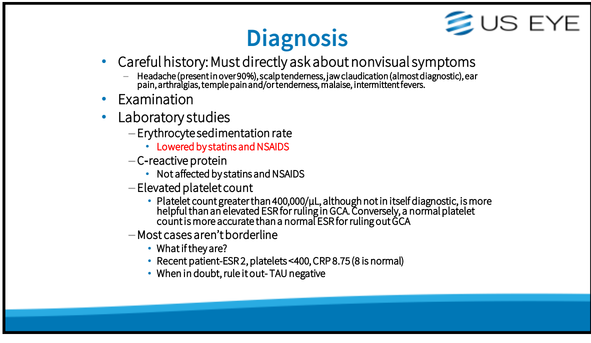
78 year old female

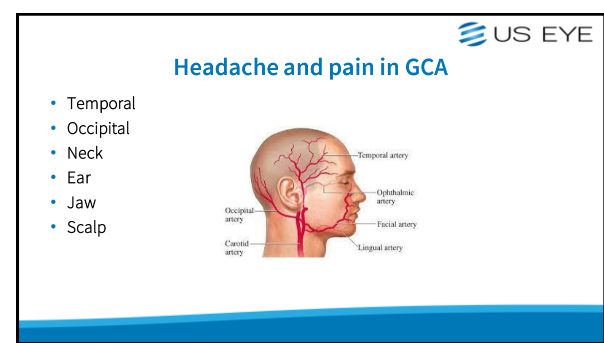
- Hx: 1 week occipital & jaw pain
- FP tx: NSAIDS
- 2 days later: 1 hr TVL OU; OD recovered; OS not
- FP tx: d/c NSAIDS: refer to ophthalmology
- Ophthalmology: suspects NSAID 'reaction'; Wait a week for NSAIDS to 'wear off' before coming in
- Next day: OD NLP ESR 117

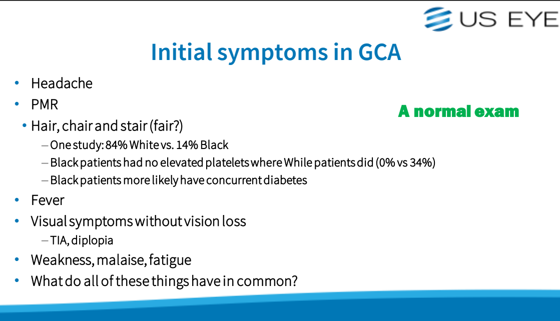
AAION

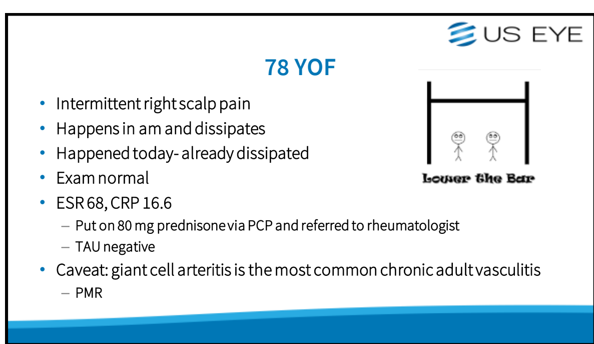
- Pallid optic nerve swelling with flame hemorrhages, arteriole attenuation and NFL infarcts
- Pain (of some sort)
- Severe optic nerve dysfunction
- Visual field defects
- Giant cell arteritis/ PMR- risk factors
- Typically 70s, uncommon under 60
- High risk bilateral involvement
  - 65% at 10 days average

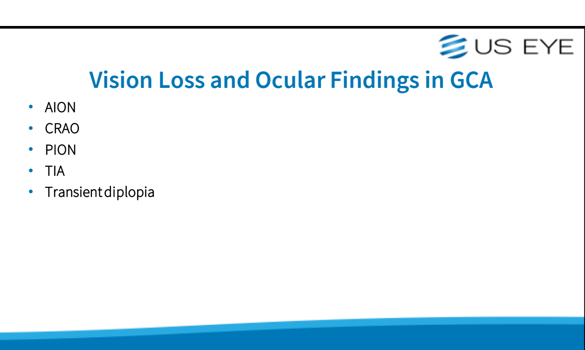


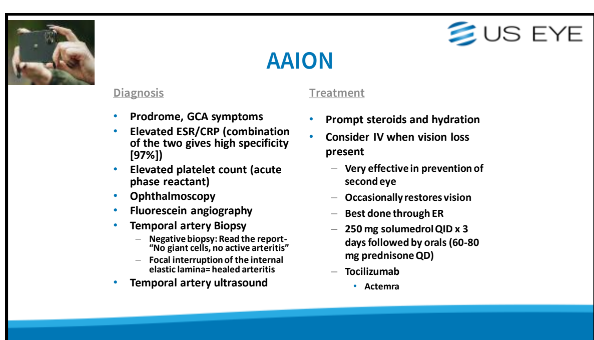

US EYE
Diagnosis
Careful history: Must directly ask about nonvisual symptoms
Headache (present in over 90%), scalp tenderness, jaw claudication (almost diagnostic), ear pain, arthralgias, temple pain and/or tenderness, malaise, intermittent fevers.
Examination
Laboratory studies
Erythrocyte sedimentation rate
Lowered by statins and NSAIDS
C-reactive protein
Not affected by statins and NSAIDS
Elevated platelet count
Platelet count greater than 400,000/µL, although not in itself diagnostic, is more helpful than an elevated ESR for ruling in GCA. Conversely, a normal platelet count is more accurate than a normal ESR for ruling out GCA
Most cases aren't borderline
What if they are?
Recent patient-ESR 2, platelets <400, CRP 8.75 (8 is normal)
When in doubt, rule it out- TAU negative

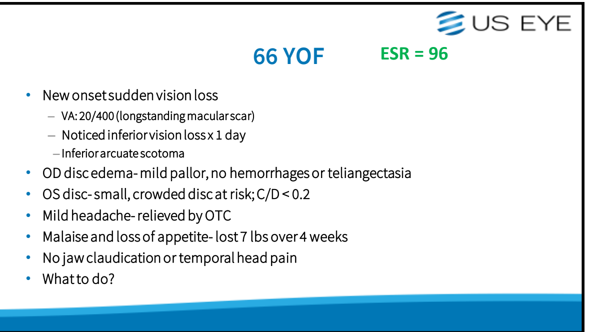

US EYE
Headache and pain in GCA
Temporal
Occipital
Neck
Ear
Jaw
Scalp
Temporal artery
Ophthalmic artery
Occipital artery
Facial artery
Carotid artery
Lingual artery


US EYE
Initial symptoms in GCA
Headache
PMR
A normal exam
Hair, chair and stair (fair?)
One study: 84% White vs. 14% Black
Black patients had no elevated platelets where While patients did (0% vs 34%)
Black patients more likely have concurrent diabetes
Fever
Visual symptoms without vision loss
TIA, diplopia
Weakness, malaise, fatigue
What do all of these things have in common?


US EYE
78 YOF
Intermittent right scalp pain
Happens in am and dissipates
Happened today- already dissipated
Exam normal
ESR 68, CRP 16.6
Put on 80 mg prednisone via PCP and referred to rheumatologist
TAU negative
Caveat: giant cell arteritis is the most common chronic adult vasculitis
PMR
Lower the Bar

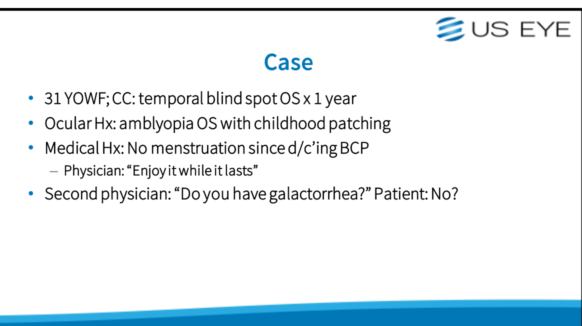

US EYE
Vision Loss and Ocular Findings in GCA
AION
CRAO
PION
TIA
Transient diplopia

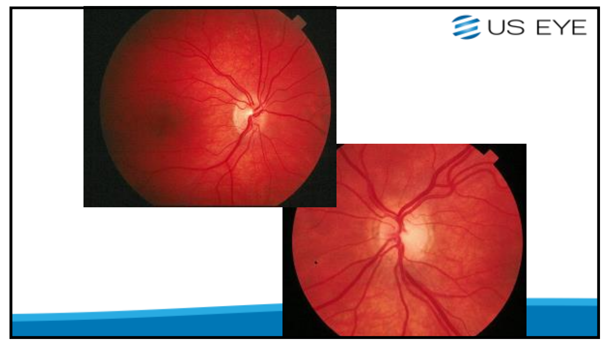

US EYE
AAION
Diagnosis
Prodrome, GCA symptoms
Elevated ESR/CRP (combination of the two gives high specificity [97%])
Elevated platelet count (acute phase reactant)
Ophthalmoscopy
Fluorescein angiography
Temporal artery Biopsy
Negative biopsy: Read the report- "No giant cells, no active arteritis"
Focal interruption of the internal elastic lamina= healed arteritis
Temporal artery ultrasound
Treatment
Prompt steroids and hydration
Consider IV when vision loss present
Very effective in prevention of second eye
Occasionally restores vision
Best done through ER
250 mg solumedrol QID x 3 days followed by orals (60-80 mg prednisone QD)
Tocilizumab
Actemra


US EYE
66 YOF
ESR = 96
New onset sudden vision loss
VA: 20/400 (longstanding macular scar)
Noticed inferior vision loss x 1 day
Inferior arcuate scotoma
OD disc edema- mild pallor, no hemorrhages or teliangectasia
OS disc- small, crowded disc at risk; C/D < 0.2
Mild headache- relieved by OTC
Malaise and loss of appetite- lost 7 lbs over 4 weeks
No jaw claudication or temporal head pain
What to do?

US EYE
ANY ACUTE VISION LOSS IN THE ELDERLY IS GCA UNTIL PROVEN OTHERWISE

US EYE
IF YOU EVER WONDER WHAT TO DO, READ THE CHIEF COMPLAINT OUT LOUD


US EYE
Case
31 YOWF; CC: temporal blind spot OS x 1 year
Ocular Hx: amblyopia OS with childhood patching
Medical Hx: No menstruation since d/c'ing BCP
Physician: "Enjoy it while it lasts"
Second physician: "Do you have galactorrhea?" Patient: No?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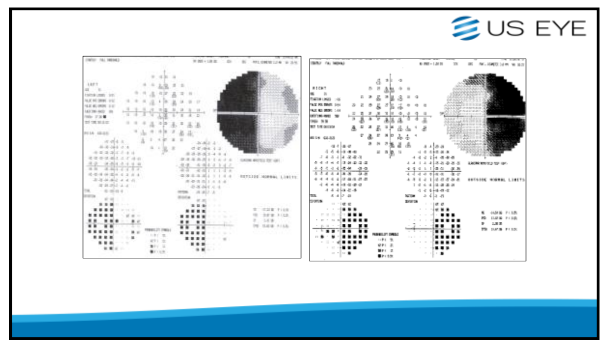

US EYE

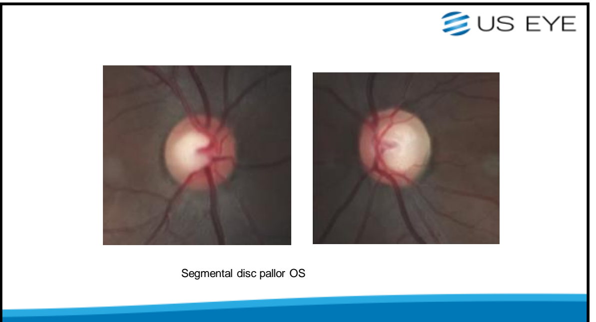
Optic Atrophy

- Cavalierly used term
- Says, “The patient has a brain tumor and I am doing nothing about it”.
- Six criteria:
  - Pallor
  - NFL defect
  - Pupil defect
  - Field defect
  - Vision defect
  - Color defect
- Don’t assume it is old

Optic atrophy

- Primary optic atrophy
  - Uniform nerve fiber degeneration, resulting in glial replacement but no architectural alteration of the optic nerve head.
  - Disc appears chalky white, but the margins remain distinct and retinal vessels appear normal.
    - Trauma and compression (e.g. tumor) causes
- Secondary optic atrophy
  - Results from pathological chronic disc edema
    - malignant hypertension, papilledema, or infiltrative diseases like leukemia or sarcoidosis.

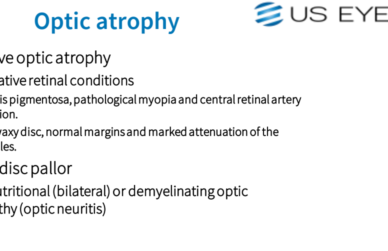
US EYE



Segmental disc pallor OS

US EYE

Optic atrophy



- Consecutive optic atrophy
  - Degenerative retinal conditions
    - Retinitis pigmentosa, pathological myopia and central retinal artery occlusion.
    - Pale, waxy disc, normal margins and marked attenuation of the arterioles.
- Temporal disc pallor
  - Toxic/ nutritional (bilateral) or demyelinating optic neuropathy (optic neuritis)

Optic atrophy

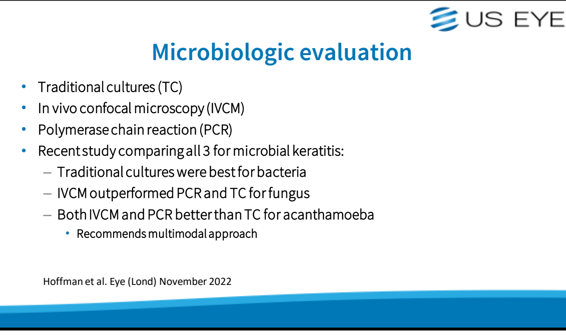
- Numerous potential etiologies
  - Infarction, infection, infiltration, inflammation, trauma, toxicity, metabolic dysfunction or direct compression of the nerve or chiasm
- Evaluation:
  - MRI studies should be obtained of the orbits, the optic chiasm and the brain with and without contrast, fat suppression for orbits, in a high field scanning unit.
    - Contrast dye (gadolinium) is beneficial in discerning malignant lesions, demyelinating plaques indicative of multiple sclerosis.

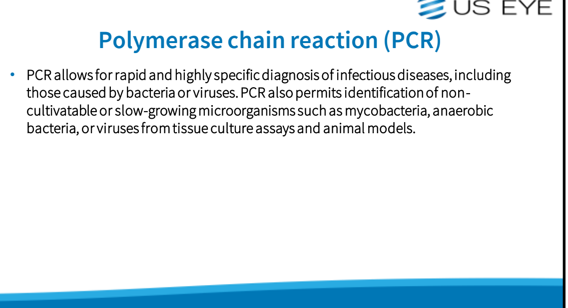
All cases of optic nerve pallor/ optic atrophy must be investigated or explained

US EYE

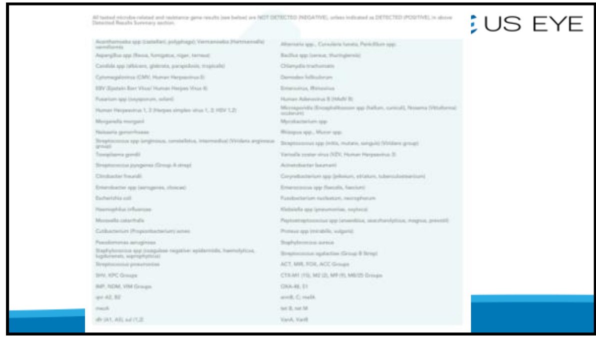
Keratitis and Malpractice

- Alleged mismanagement of keratitis
- Few can argue with a good outcome (but some still will)
- Steroid use
  - Follow closely
- Always consider herpes
- Always consider alternate diagnoses- Most treat for bacteria
  - Protozoan, fungus
- Need to temper time needed for resolution vs. when to do something different
- Bad outcome- first question: “Where is the culture?”
- Bad outcome- second question: “Why didn’t you refer to a corneal specialist?”


US EYE
Microbiologic evaluation
• Traditional cultures (TC)
• In vivo confocal microscopy (IVCM)
• Polymerase chain reaction (PCR)
• Recent study comparing all 3 for microbial keratitis:
– Traditional cultures were best for bacteria
– IVCM outperformed PCR and TC for fungus
– Both IVCM and PCR better than TC for acanthamoeba
• Recommends multimodal approach
Hoffman et al. Eye (Lond) November 2022


US EYE
Polymerase chain reaction (PCR)
• PCR allows for rapid and highly specific diagnosis of infectious diseases, including those caused by bacteria or viruses. PCR also permits identification of non-cultivatable or slow-growing microorganisms such as mycobacteria, anaerobic bacteria, or viruses from tissue culture assays and animal models.

BIOHAZARD
Core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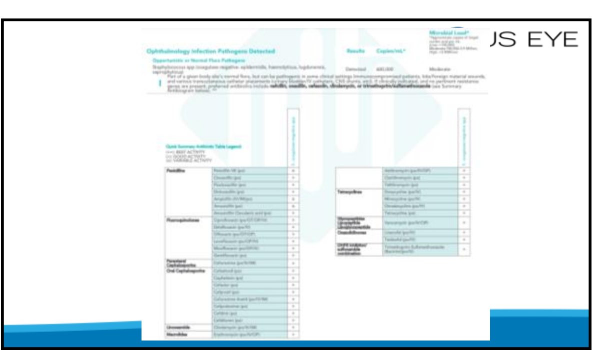
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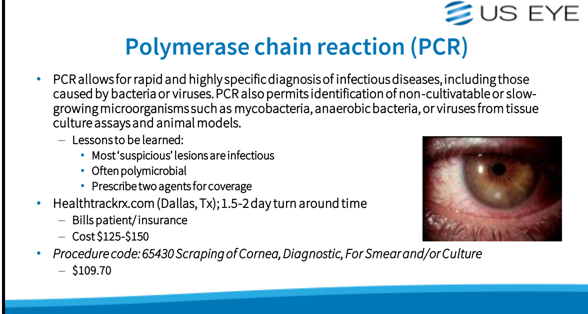
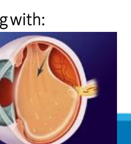
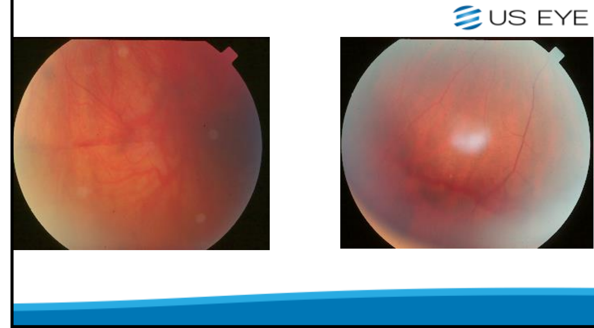

US EYE
Polymerase chain reaction (PCR)
• PCR allows for rapid and highly specific diagnosis of infectious diseases, including those caused by bacteria or viruses. PCR also permits identification of non-cultivatable or slow-growing microorganisms such as mycobacteria, anaerobic bacteria, or viruses from tissue culture assays and animal models.
– Lessons to be learned:
• Most 'suspicious' lesions are infectious
• Often polymicrobial
• Prescribe two agents for coverage
• Healthtrackrx.com (Dallas, Tx); 1.5-2 day turn around time
– Bills patient/insurance
– Cost $125-$150
• Procedure code: 65430 Scraping of Cornea, Diagnostic, For Smear and/or Culture
– $109.70

PVD and RD

- As hyaluronic acid concentration decreases with age, collagen fibrils lose support, aggregate, form pockets of liquefied vitreous (lacunae), and the vitreous collapses resulting in a posterior vitreous detachment (PVD). As the vitreous collapses, traction is exerted on areas of vitreoretinal adhesion and a tear can result.
- In a study of 589 symptomatic patients, those presenting with:
  - Diffuse spots: 52% had a retinal tear
  - Vitreous cells: 65% had a retinal tear
  - Vitreous blood: 91% had a retinal tear



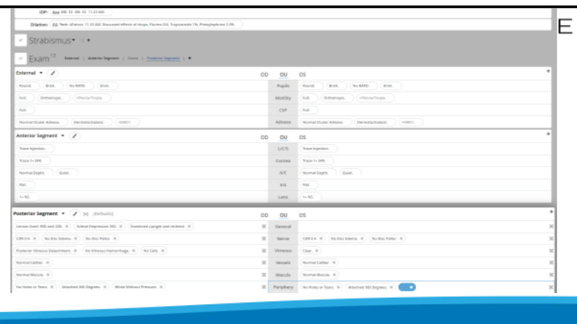


Acute PVD

- Acute PVD has a 15% likelihood of having a retinal tear at initial presentation.
  - ½ will have more than one tear.
- If there are no retinal defects seen, repeat examination in 1-2 weeks.
  - Statistically, most retinal complications from PVD occur within the first 6 weeks (about 3%-5% will develop a late-onset retinal break).
    - Most cases that I have seen progress in 1-2 weeks
- If no complications develop within 6 weeks, routine yearly follow-up is indicated, unless symptoms change.
  - Research indicates follow up is only necessary if there is an increase in symptoms. However, not everyone has adopted this philosophy and you probably shouldn't either.

Complicated PVD

- When encountering an acute PVD with vitreous or pre-retinal hemorrhage, but no discernible break (examining with Goldmann 3-mirror fundus lens, non-contact lens, BIO, scleral depression, and consulting a psychic), re-examine every 1-2 weeks for 6 weeks (or get a second opinion).
- If no break is seen, re-examine at regular intervals until the hemorrhage clears. The concern is that there is a retinal break that also tore a blood vessel.
  - If no break is ever found to account for the hemorrhage, then the likely cause is rupture of superficial capillaries caused by the PVD.
    - Small amount of inferior hemorrhage and/or bloody Weiss ring
    - Larger amounts of obscuring hemorrhage is more concerning
- Record everything that you do: drops used, lens used, saw ora 360, scleral depression (if you did it), examined upright and/or supine



An RD Case

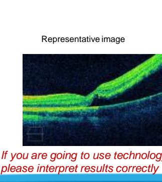
- Pt c/o floaters
- Examined by OD who dilates, performs BIO, finds retina intact, warns Si/Sx RD; RTC ASAP any changes
- Pt experiences vision reduction on a Thursday, somewhat worse on Friday- wants to see if it will 'clear up'
- Comes in Monday with macula off RD
- Sues OD
- Expert witness (OD): "*He didn't look well enough*"

Snatching defeat out of the jaws of victory

US EYE

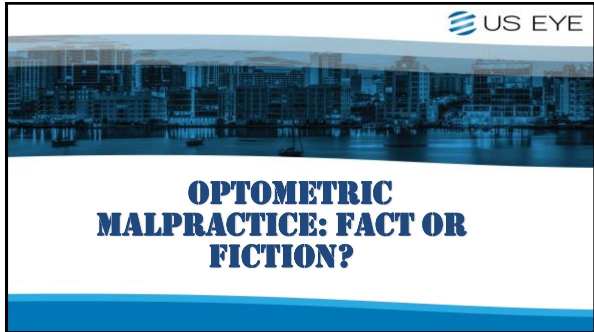
- Pt presents with reduced acuity (20/50)
- OD diagnoses CSC based upon OCT
  - Doesn't dilate to confirm
- Case goes to trial- OD prevails
  - Poor expert witness for plaintiff
- Verdict gets overturned on appeal
  - Technicality
- Goes back into litigation

Representative image



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

US EYE



OPTOMETRIC MALPRACTICE: FACT OR FICTION?

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
- Common errors
  - Trying to win the case
  - Thinking that you *must* go all the way through

US EYE

Patient Considerations

- Some patients have been legitimately wronged
- Some patients are just angry and looking to blame
- The economy can enhance malpractice claims
- Patient depositions are mind-numbingly boring
  - It is the assessment factor
- Common patient complaints
  - Vision loss, field loss, loss of abilities to lead normal life, constant *dizziness** (from field loss), intractable *headache** (from field loss)

US EYE

If you are sued for malpractice, the plaintiff's attorney will have as an expert witness an ophthalmologist that hates optometry.

Fact or Fiction?

If you are sued for malpractice, the plaintiff's attorney will have as an expert witness an ophthalmologist that hates optometry.

Fiction

Polling Question 1: If an attorney thinks that there has been negligence, he/she can sue you for malpractice

Fact or Fiction?

Polling Question 1: If an attorney thinks that there has been negligence, he/she can sue you for malpractice

Fiction

Plaintiff Case

- Patient being treated for glaucoma
- History of POHS and CNV- treated with Avastin
- Moderate cupping; IOP 22 mm OD and 24 mm OS
  - Glaucoma diagnosis dodgy, but I wasn't there
- Patient develops advancing field loss, then acuity loss
  - 6 month period
- Pt gets referred to ophthalmology, then to retinal specialist, then to neuro-ophthalmologist
- Pt has optic nerve sheath meningioma
- Patient and family very angry
- Slam-dunk malfeasance, eh?
- *"Do you want my opinion or do you want me to tell you what you want to hear?"*
  - Attorney knows very little about the eye

The Facts as I See Them

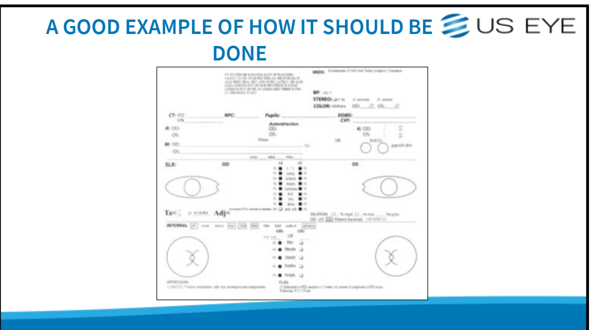
- Patient has multiple diagnoses
  - Glaucoma (?), POHS, retinal vision loss
  - ONSM represents <2% of all orbital tumors
- Some delay in diagnosis: about 6 months
  - Would it make a difference?
  - Bad things happen when optic nerve is involved

Plaintiff Case: Flashes and Floaters

- Pt has symptoms on Monday- examined with PVD; educated
- More symptoms Saturday
- Seen Sunday- RD
  - No record of encounter at all
  - *"Oh, Crap, you have a retinal detachment"*
  - Seen Monday by retinal specialist
    - Pt is NPO
    - Has surgical repair
  - Pt seeks attorney and wants to sue
  - Asked to opine against OD

A GOOD EXAMPLE OF HOW IT SHOULD BE DONE

US EYE



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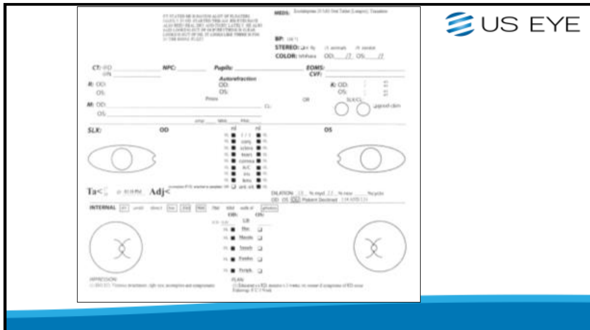


US EYE

The Facts as I See Them

- Everything is in the chart clearly
  - Dilation
  - Meds used
  - Lenses used
  - Good description of condition
  - No subsequent charting of Sunday visit, but pt reported NPO on Monday
    - Ergo, the exam did happen
  - There was a change in symptoms, consistent with literature
  - *"Do you want my opinion or do you want me to tell you what you want to hear?"*
  - In all medical probability, there was *not* a tear at the time of the initial exam

Bad Outcome vs Malpractice

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

US EYE

Bad Outcome vs Malpractice

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

US EYE

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

US EYE

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
- No fields
- Frame style, bifocal style, seg height, PD, temple length, A/R coating, tint, all charges recorded
- Is this malpractice? Are allegations accurate?

US EYE

Cases of optometric malpractice typically involve obvious negligence and are clearly straightforward.

Fact or Fiction?

Cases of optometric malpractice typically involve obvious negligence and are clearly straightforward.

Fiction

Not Black and White but Shades of Gray

- Retained as defense expert
- Pigmentary glaucoma
- IOP uncontrolled- 32 mm OD
- Patient doesn't like meds
- Doctor completely changes regimen
- Schedules 6 month appointment
- Multiple surgeries- LP vision
- Sues 2 doctors for $2M each

Sometimes it is Black and White

- Retained as defense expert
- Pt seen for 15 years by OD
- Loses field/ fixation- pigmentary glaucoma
- Records illegible; c/d seems to be symbols?
- IOP ranges from 12 – 29 mm Hg: no eval.
  - Brings patient back- IOP lower – no problem!
- Recommendation: settle

US EYE

There is no such thing as practicing "defensive medicine".

Fact or Fiction?

US EYE

There is no such thing as practicing "defensive medicine".

Fact

US EYE

Revisiting Pigmentary Glaucoma

- Patient being managed in VA
- Goes to private OD- IOP 47 mm Hg
- Referred emergently to another center
  - seen 3 days later
  - IOP 21
- Returns 2 months later - IOP 53 mm Hg
- Referred emergently- seen next day
- Sued for $2M for not being referred "fast enough"

US EYE

DEFENSIVE MEDICINE?

- Woman has "normal" exam with OD
  - Complaints of HA; diplopia- not addressed
    - Pt declines field testing; conf normal
- Sees another OD 10 mos later (12/9)
- Diagnoses "papilledema"- makes referral to retinal specialist
  - Urgency unclear
- Sees general ophthalmologist (1/15)
  - Refers STAT to ER
- What are the implications? He *did* refer.

US EYE

The majority of optometric malpractice involves inappropriate use of therapeutics.

Fact or Fiction?

US EYE

The majority of optometric malpractice involves inappropriate use of therapeutics.

Fiction

US EYE

Three Main Offenders

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

US EYE

In Other Words…

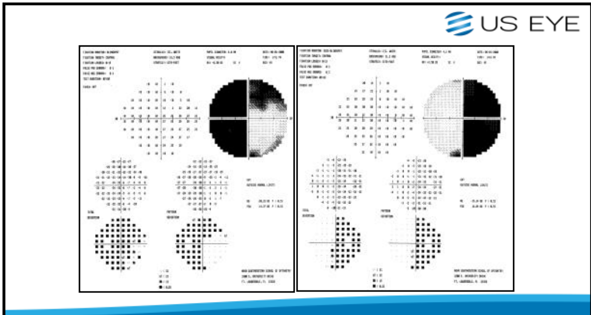
- Failure to listen to the patient
- Failure to observe the signs
- Failure to make the diagnosis fit the findings
  - Not vice-versa!
- Failure to do the appropriate tests and follow-up
- Failure to make the proper referral

US EYE

Failure to Listen to the Patient

- 47 YOHM
- CC: Consistently reports "Hazy" vision OS
  - Seen by OD 16 months earlier: "Microesotropia"; VA 20/25 OS (20/20 OD)
  - Seen by another OD 6 months later: "Dry Eye". Same acuity.
- Today: 20/20 OD, 20/70 OS
- Pupils: PERRL (+) RAPD OS (trace)
- Motility: full
- Fields: OS temporal defect on confrontation
- Color: 12/13 OD, 1/13 OS

US EYE



US EYE

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.

US EYE

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

US EYE

Failure to Make the Diagnosis Fit the Findings

- 58 YOWF – awakened with pain, photophobia, lacrimation
- Previous exams normal
- Corneal edema and punctate epitheliopathy OD
- History:
  - Had cleaned house day and a half earlier
- Diagnosis: chemical keratitis
  - "But I felt fine afterwards"
- Treated with Tobradex QID

US EYE

Failure to Make the Diagnosis Fit the Findings

- Worsens with advent of nausea and emesis
- Seeks second opinion
- IOP 58 mm Hg OD
- Acute angle closure
- Failure to do the appropriate tests and follow-up
- Recommendation: Settle

US EYE

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

US EYE

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*"

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; reappointed
- Dismissed

Failure to Diagnose Retinal Detachment

- Patient has worsening of symptoms and vision loss one week later
- Telephones optometrist who immediately directs patient to friendly 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?

Polling question 2: Anything not recorded in the patient's chart is considered "not performed".

Fact or Fiction?

Anything not recorded in the patient's chart is considered "not performed".

Fiction

"Not written …Not done" is not true

US EYE

Failure to Diagnose Retinal Detachment

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

US EYE

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 thanks"

US EYE

Failure to Diagnose Retinal Detachment

- "Friendly" retinal specialist deposed
- Plaintiff attorney: "Could Dr. XYZ have missed the retinal break?"
- "Friendly" retinal specialist: "Well, yes. It is likely he did. He is not a physician, you know".
  - *Does this bother anyone out there?*

US EYE

Legal Pot of Gold

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. "*

US EYE

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.

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***".

US EYE

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

US EYE

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

US EYE

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.

Polling question 3: Never make a late "amendment" to a chart

Fact or Fiction?

US EYE

Polling question 3: Never make a late "amendment" to a chart

Fact

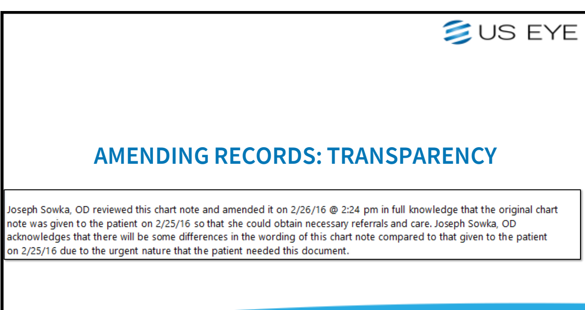
US EYE

The Diabetic "Referral"

- Pt initiates case against OD for vision loss from DR
- First attorney becomes disinterested- drops
- Second attorney retained- gets "amended" record
- Retained as defense expert
- What happens if 2nd attorney gets record from 1st attorney?

US EYE

AMENDING RECORDS: TRANSPARENCY



Joseph Sowka, OD reviewed this chart note and amended it on 2/26/16 @ 2:24 pm in full knowledge that the original chart note was given to the patient on 2/25/16 so that she could obtain necessary referrals and care. Joseph Sowka, OD acknowledges that there will be some differences in the wording of this chart note compared to that given to the patient on 2/25/16 due to the urgent nature that the patient needed this document.

US EYE

Virtually anything can be defended except the appearance of dishonesty

Fact or Fiction?

US EYE

Virtually anything can be defended except the appearance of dishonesty

Fact

Tobradex…Tobrex…Tobradex

- 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…

Polling question 4: If the diagnosis is never correct, the patient can't sue for malpractice

Fact or Fiction?

Polling question 4: If the diagnosis is never correct, the patient can't sue for malpractice

Fiction

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, orders MRI (normal)- diagnoses optic neuritis and steroid induced IOP rise
  - Injects steroid
- All 3 sued for missing steroid induced glaucoma
- Does any glaucoma cause a swollen nerve?

PLAINTIFF EXPERT WITNESS (MD)

- *"Any delay in treatment was significant because the glaucoma progressed at an unusually rapid rate"*
- *"Disc pallor is common in glaucoma"*
- *"Glaucoma happens commonly with small cups"*
- *"When the IOP is very elevated, it often causes a swollen nerve"*
- *"You never consider ischemic optic neuropathy in a patient under 70 years"*

US EYE

A Festival of Ignorance: Part II

- 55 YOF; cerebral palsy; poorly communicative; some discomfort OS
  - NLP OD; 20/200 OS; -13.00 DS OS
  - 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

US EYE

YOU'D BE SURPRISED WHAT CAN BE DEFENDED

- 17 YOF-Develops blur OS (20/50) in March
- Sees OD in June
- Diagnoses amblyopia
  - Amblyogenic factors unclear
- Recommends second opinion

US EYE

YOU'D BE SURPRISED WHAT CAN BE DEFENDED

- Goes to MD in June
- Vision 20/100
- Suspects RD
- Refers to retina

US EYE

YOU'D BE SURPRISED WHAT CAN BE DEFENDED

- Refers to retina- seen next day
  - 20/400- macula off RD
  - Completely blows surgery- LP
- Is this THE NIGHTMARE? "Amblyopia" that was RD
- Is this defendable?
- How much damage could be mitigated?
- Who is at fault? OD? Patient? Surgeon?
- Pt has very convenient memory

US EYE

A malpractice suit gets you reported to your state board and can cause you to lose your license.

Fact or Fiction?

US EYE

A malpractice suit gets you reported to your state board and can cause you to lose your license.

Fiction

US EYE

Case: Alleged Negligence

- Lawn/ tree service worker presents with corneal abrasion
  - No hx of vegetative matter given
  - 3 days of FB sensation; no complaints of vision loss
- Geographic abrasion and edema without infiltration
  - Treated with Maxitrol and bandage CL- f/u 2 days
    - RTC immediately if any changes
- Pt returns 2 days later with severe central corneal infiltration
- OD recognizes possibility of fungal infection- tries to refer immediately

Case: Alleged Negligence

- Pt wants to 'wait to see if it gets better'
- Workers comp- referral authorization will take 'at least a week'
- OD adamant- explains fungal infection and permanent vision loss
- Pt ultimately referred and seen next day and treated for bacterial keratitis despite OD note about fungus
- After 7-10 days of not improving, pt referred elsewhere and dx'ed with fungal keratitis

US EYE

Case: Alleged Negligence

- Pt initiates litigation against OD
- Referral center recognized issue and offered compensation in advance of litigation, so was not sued
- Pt leaves country, not participating in legal process- case dies
- Pt' s attorney vindictively* reports OD to DOH for license sanctions

*personal editorial

Case: Alleged Negligence

- DOH Expert:
  - OD violated Chapter 463.0135(1) by failing to provide the degree of medical care provided by similarly trained medical practitioners in the same or similar communities
    - Treated corneal abrasion with antibiotic-steroid combination
      - Use of antibiotics alone is standard of care
    - Using steroid for vegetative corneal injury
    - Failed to timely refer fungal keratitis

US EYE

The Facts as I See Them

- No hx of vegetative injury ever given by pt to anyone
  - DOH broad speculation based upon employment and final diagnosis
- Steroid-antibiotic combo reasonable for corneal abrasion
- No indication of fungal keratitis at first visit
  - Prophylactic natamycin? Refer abrasion to corneal specialist? What more could OD do?
- OD was first to consider fungus, but nobody listened
- What would have happened if OD used standard of care treatment with topical antibiotics alone?

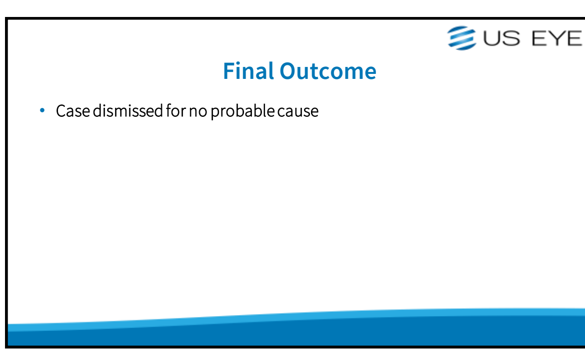
Final Outcome

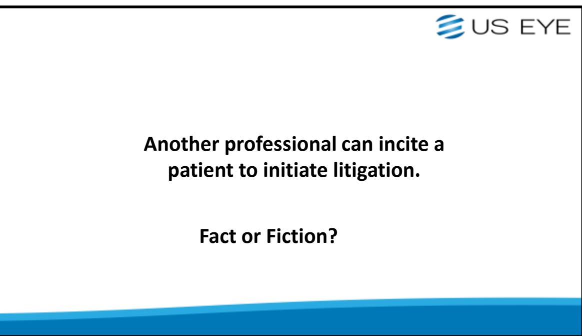
- Case dismissed for no probable cause

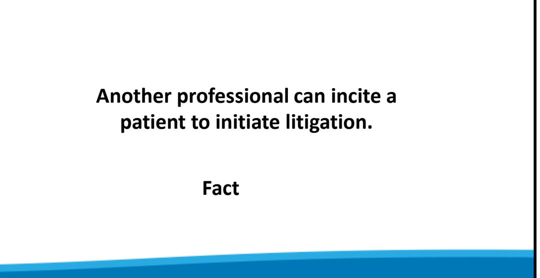
US EYE

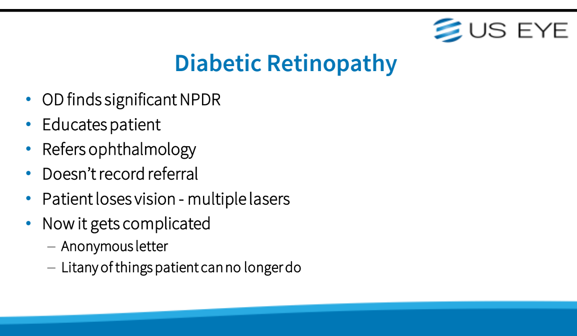
Do as I say…or else

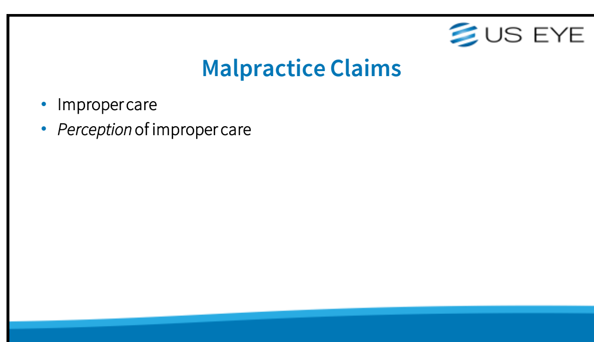
- Female presents to OD
- Demands 1 year refills on timolol
- Refuses any additional testing or follow up
- Doctor declines…gets reported to DOH











US EYE

The attorney is representing the insurance company and not you. You should personally retain a separate attorney at your own expense.

Fact or Fiction?

The attorney is representing the insurance company and not you. You should personally retain a separate attorney at your own expense.

Fiction

Malpractice- How to Avoid it

- Put patients' needs over doctor's needs
- Do not make findings fit diagnosis
- Do not be afraid to investigate further
- Insist that everything make sense
- Do not disregard patient complaints
- Check drug facts and print out medical prescriptions
- Document! Document! Document!
  - Can't defend five words on a chart
- DFE- Fields- MRI- Second opinion

Surviving the deposition

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
    - I'll talk you off the ledge

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

US EYE

US EYE

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"

MY COUSIN VINNY

WHAT'S A UTE?

US EYE

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

US EYE

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

US EYE

Look in the mirror

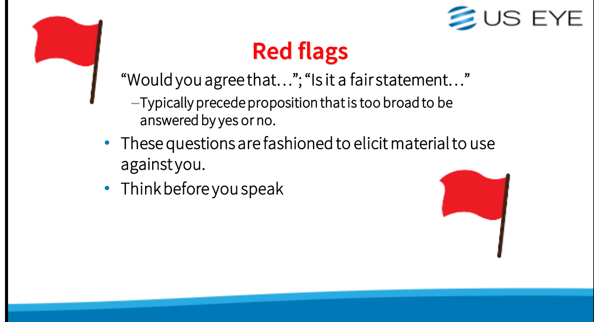
- Appearance and demeanor as important as testimony*
  - Be neat
  - Avoid anger, hostility, condescension*
    - *"ODs are just failed physician wannabes"*
      - 172 medical schools; just 23 optometry colleges
- Questions phrased to make you appear dishonest*
  - Keep concentration and composure
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

*It's not personal...it's just business

US EYE

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 after answering
    - Not before- becomes adversarial



US EYE

Red flags

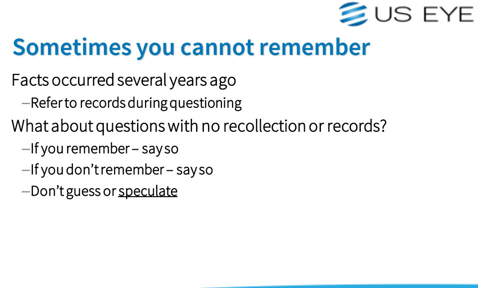
"Would you agree that…"; "Is it a fair statement…"
- Typically precede proposition that is too broad to be answered by yes or no.

- These questions are fashioned to elicit material to use against you.
- Think before you speak

US EYE

One at a time

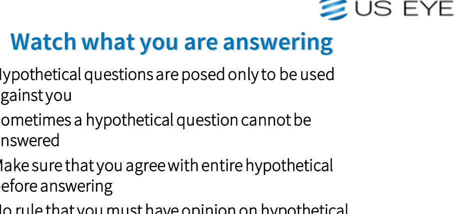
- Let attorney finish question before answering
  - Understand question before responding
  - Court reporter can only transcribe so fast
    - Complete question won't be in transcript
  - Your attorney has time to voice objections
- Be sure that entire question is accurate before saying yes
  - If any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



US EYE

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 speculate



US EYE

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

US EYE

- 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 and prepare
- 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

US EYE

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.