Risk Management In Optometric Practice…
How to survive in the medical-legal jungle

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“It seems you have not done the things you were supposed to do. Therefore Mrs. Jones, I am going to sue you for **MALPATIENT**!”
Principles Of Medical-Legal Issues In Eye Care

- Documentation / Medical Record Keeping
- Standards of care
- Informed consent
- Informed refusal
- Abandonment
- Failure to refer
Associated Issues In Ophthalmic Claims

- **Diagnostic errors**: most frequent and second most expensive

- **Treatment errors**: inappropriate tx, complications of tx, etc.

- **Failure/delay in referral**: less frequent, but the #1 most expensive
Documentation and Medical Record Keeping

- “If it’s not documented…it was not done”
- **Case history**
  (c.c., ocular sx’s, poh, feh, systemic medical hx)
- **Physical findings**
  (“neg.” is not enough)
- **Copies & analysis of Dx tests**
  (vf, gonio, etc.)
Standards of Care Issues

◆ “Prudent Practitioner Principle”
  what would a reasonable and prudent practitioner do under similar circumstances
  
  ◆ Appropriate Dx, Tx, & referral
  
  ◆ Egs: gonio on narrow angles, performance of threshold VF’s in glaucoma, etc.

  ◆ Standards of care change: pachymetry in glaucoma management
“Informed Consent” - What To Discuss & Do

- Diagnosis & prognosis
- Recommended procedures & Tx
- Potential risks
- Alternative Tx’s
- Consequences of no Tx – “R/B/A”
- Ask for, and answer all questions
- Document, Document, Document
“Informed Refusal”

- Pt. refuses Dx tests, treatments, or referral
- Must inform pt. of risks of refusal & document it
- Egs. in glaucoma: tonometry, dilation, vf’s, medications, surgery
“Abandonment”

- **Damages** suffered following termination of care
- **Dr. is responsible** for patient’s health until proper termination

- **Key situations**: failure to keep appointments, failure to go to referral, failure to pay for services

- **Actions**: certified letter, provide record copies, document efforts in record
“Failure To Refer”

- “Timely referral”
- Referral to a “specialist”
- Most expensive of all ophthalmic claims
- Explain to patient: why, who, where & when. Then document and follow up
The case of: “I’m missing you!”

A 46 yo M lawyer had successful LASIK performed at a large refractive surg. practice. 1 wk. s/p c/o a “change in vision and veil over his vision superiorly” over past 2 days.
The case of “I’m missing you!”

- Sees OD who does post ops. Performs acuities (20/20 bva), SLE, dilates and does BIO. All normal (no tears, RD, ant. seg. normal). Adv. 1 mo f/u unless sx’s get worse. Sx’s likely post LASIK fluctuations.
“I’m missing you!”

- Patient does not show for 1 mo. f/u, but comes in 2 mo. latter c/o vision much worse in the eye, can not see anything!
“I’m missing you !”

- Va now “finger counting”, pt. seen by staff MD and referred to retinal specialist, Dx of large retinal detachment involving macula.

- Surgery is performed with residual Va of 20/200 in the eye. Pt. claims loss of vision interferes with ability to practice law.
Plaintiff’s expert states: “OD was not qualified to detect RD and should have referred to an ophthalmologist at the first visit.”

Insured states: “there was no detachment at the first visit and no referral was indicated. The patient failed to follow up in 1 mo.” and therefore the insured was not at fault.
“I’m missing you !”

Issues at hand

- Failure to diagnose
  (orig. sx’s, no vitreous exam, no field test, likely “flat RD” with missed break)

- Failure to refer (at orig. exam based on sx’s alone, referral to a “specialist”)

- Failure to follow up
  (after missed 1 mo. visit)

- The OD vs. MD in original diagnosis is a non-issue
The case of: “How dry I am !”

A 53 yo F was fit with bif. scl’s by an OD, she had prev. worn monov. scl’s for 19 yrs. 2 mo following she removed her lenses and felt “a ripping sensation”. She went to an ER and was tx’d for a lrg. abrasion. Follow up w/ an ophth. dx’d bilat. “dry eye and epith. basement membrane dystrophy w/ secondary recurrent corneal erosion”.
“How dry I am!”

- Treating MD states that future contact lens wear is unlikely due to the status of the cornea and that ongoing tx or “corneal surgery” may be necessary.
“How dry I am!”

Insured OD did not want to settle. He feels he is not liable since “corneal abrasions can occur with contact lens wear removal, especially if re-wetting drops are not used prior to removal”. 
“How dry I am !”

Issues at hand

- **Failure to diagnose**
  (EBMD & dry eye prior to cl fitting)

- **Poor documentation** (no specific notation of SLE findings, dry eye testing, or case assessment i.e. “SOAP” format)

- **Informed consent** (no notation, form, or signature re-risks of cl w/ dry eye and EBMD).
The case of: “Dot, you can’t blame me!”

◆ A 35 yo F presents to an OD at a large eye clinic for routine eye care & CL fitting. Hx is + for type 1 DM of 15 year duration.

◆ Va 20/25 OD/OS, notes of “dot” hemorrhages OU and a “cotton wool spot” OS.

◆ Referral was made to a general staff ophthalmologist for consult and the OD continued to provide CL care for 1 yr.
“Dot, you can’t blame me!”

Latter the next year the pt. experienced “floaters” and decreased vision OS to 20/50. A dx of central hemorrhage was made by the staff ophth. and referral was made to a retinal specialist. Laser surgery and vitrectomy was eventually performed, but only LP remained OS.

The staff ophthalmologist was the primary defendant, but the OD was also sued based on failure to refer properly.
“Dot, you can’t blame me!”

**Issues at hand**

- **Limited concentration of care** (OD performed only CL related care following referral to the ophthalmol.)

- **Standard of care** (based on ETDR studies and the AOA optometric clinical practice guidelines for diabetes)

- **Failure to refer to a “specialist”** (OD referred to general ophthalmol.)
The case of:
“A geranium in the cranium”

- A 38 yo M treated by an OD for routine eye care and CL’s since 2000. Computerized VF testing was performed by techs prior to each exam (results printed and given to Dr.). VF tests of 2000 and 2001 were nl. with all pts. seen. 2002: 10 pts. of 76 were missed OD, and 17 OS. In 2003 a similar # were missed, in 2004 he missed 14 OD and 21 OS. In 04 there were sx’s of “blurry vision”, testing focused on CL issues.
Dec. of 05 the patient was admitted to a hospital ER & dx’d with a pituitary adenoma which invaded the ethmoid sinus causing fracture of the sinus and leakage of CSF into the nasal cavity! The patient underwent multiple surgeries, lumbar punctures, and medical therapy for inhibition of tumor re-growth.
“A geranium in the cranium”

- Plaintiff’s expert (a neuro-ophthalmologist) states:

  “The visual field defects were so obvious that a medical student would have found the problem. Early diagnosis would have avoided the ethmoid fracture and invasion.”
“A geranium in the cranium”

Issues at Hand

- Failure to diagnose
- Failure to refer
- Failure to supervise staff
- “If you perform high tech tests - use the information!”
“A sticky situation!”

- A 31 yo F saw an OD for a CL exam while visiting from out of town. An eye exam was performed and CL’s dispensed. A notation of "unusual pigmentation of the cornea" was made in the chart. IOP’s by NCT were 15 OD & 18 OS. No notation of disc status or visual testing was made. No follow up care recommendations were documented.
5 years latter the patient was diagnosed with pigmentary glaucoma OS, having advanced cupping and marked visual field loss. The OD was found to have pigmentary dispersion syndrome without glaucoma.

Plaintiff claims that the dx was missed which could have avoided subsequent vision loss OS.
“A sticky situation!”

Issues at Hand

- Poor record documentation
- Failure to diagnose PDS & therefore failure to provide informed consent information
- Failure to refer?
A 34 yo female presents to an OD’s office interested in refractive surgery. The OD takes a history which indicated that she was being treated for “arthritis” and was taking plaquinil. An exam was performed consisting of manifest refraction, SLE, and fundus. Dry eye was noted in the plan section with intention to use punctum plugs at the first post-operative visit. The patient was referred to a local refractive surgeon of less than stellar reputation.
Similar historical notes were made in the OMD’s chart without further probing. LASIK surgery was performed bilaterally. The patient was seen on day 1 post-op by the OD. Vision was 20/80, and 20/70. No call was made to the OMD and follow up was performed on day 3 post-op. Acuity then was 20/100 and 20/80. The first call was made to the OMD that day. The patient was seen by the OMD that day. A decision was made to perform bilateral enhancement, which was conducted on day 14!
Over the subsequent weeks vision continued to deteriorate along with increasing pain bilaterally. A series of changes in topical and oral medications were made by the OMD and followed by the OD. The ultimate result was bilateral corneal melts with a residual acuity of 20/60 OU. Referral was made by the OMD to a cornea specialist by the 3rd month. Ultimately the patient sued the OMD and the co-managing OD.
The Candidate

Issues at Hand

- Failure of Informed Consent
  (by both the OD and OMD re the risks of corneal melt in patients with rheumatoid arthritis)

- Failure to consult and refer in a timely manner
  (by the OD at day 1 and the OMD to a corneal specialist earlier)

- Gross Treatment Errors
  (by the OMD in regard to early enhancement and over use of topical and oral steroids and NSAIDS)
The case of “Don’t pressure me!”

A 70 yo F presents with symptoms of vague ocular discomfort which seem to come & go over the past week. She primarily complained of irritation and a pressure feeling OD. She further states that her vision gets blurry at times. She used tear drops which seemed to help, but she wanted to make sure everything was “OK” with her eyes.
"Don’t pressure me!"

- A limited exam was performed on her unscheduled visit. BVA was 20/20- for each eye (unchanged), SLE was unremarkable (clear corneas, quiet conj., open angles, trace NS OU). IOP’s were 17 OU. Retinal evaluation was unremarkable. The patient was advised to call if symptoms got worse or persisted.
“Don’t pressure me!”

◆ 3 days latter the OD received a call at home at 8PM while he was reportedly on the way out of his home. The patient reported significant redness, blur, pain, and swelling of the right eye. The patient asked if it was ok to go her local ER since she lived a distance away. The OD suggested that she be worked up for poss. orbital cellulitis (he confused her with another patient).
“Don’t pressure me!”

Latter that night the OD received a call from the patient’s son (a personal friend) informing him that she was dx’d with acute angle closure (IOP was 58). She was treated with topical and oral medications, and was referred for bilateral PI’s the next day.
Issues at Hand

- **Failure to diagnose** (narrow angles capable of closure & sx’s consistent with intermittent angle closure)
- **Failure to refer**
  (to a glaucoma specialist for PI’s)
- **Failure to provide immediate care**
  (more of an ethical issue)
Beware For Whom The Bell Tolls!
Risk Management
In Corneal Reshaping Practice
Corneal Reshaping
Specific Medical-Legal Issues

- Limited, but increasing scientific data pertaining to safety and efficacy
- Purposeful manipulation and modification of tissue
- Utilization in children and adolescents
- Increasing number of reports pertaining to complications (some reportedly vision threatening)
- “O” vs. “O” issue (CRT primarily an optometric driven treatment modality)
- Lack of standardization for risk management
“Informed Consent” - What To Discuss & Do

- Diagnosis & prognosis
- Recommended procedures & Tx
- Potential risks
- Alternative Tx’s
- Consequences of no Tx
- Ask for, and answer all questions
- Document, Document, Document
Corneal Reshaping Therapy (CRT), also known as accelerated orthokeratology, is a non-surgical treatment method to reduce nearsightedness (myopia) and/or astigmatism. The process involves the use of specialized “reverse geometry” gas permeable contact lenses that are specifically designed to alter the topography (curvature) of the cornea. Following removal of the contact lenses visual acuity improves beyond pre-treatment levels and will most often improve vision to normal 20/20 eyesight without the use of glasses. The vast majority of cases achieve at least 20/40 or better visual acuity without glasses. This criterion allows for driving without the restriction of corrective lenses. The CRT contact lenses will need to be worn as a “retainer” for limited periods of time (typically while sleeping at night) in order to maintain the therapeutic effect. The results of CRT will vary to some degree from patient to patient, but are typically related to the degree of refractive error (i.e. prescription levels). Although results are typically excellent for appropriate candidates, results cannot be guaranteed due to individual cornea and eye response variability. Our practice will make every effort to achieve maximum therapeutic effect for all of our patients. Con’t.
ADDITIONAL INFORMATION FOR CONSENT TO TREAT:

Risks of CRT and Contact Lens Wear: any deviations from the prescribed lens wear regimen or incorrect use of solutions or contact lens disinfection procedures can result in lens damage, eye irritation, infection, or potentially a loss of vision. The use of contact lenses, including CRT lenses, may result in eye infections, inflammations, or potentially loss.

In the unlikely event of complications associated with contact lens wear and CRT, there is a possibility of eye pain, redness, infection, or loss of vision. Immediate professional attention to any complications will significantly reduce the likelihood of ocular damage or vision loss.

In cases of emergency, please contact our office immediately. During non-office hours our practice has a 24-hour emergency service. Call (phone number) and our service will page one of our doctors.

All appointments must be kept as scheduled. If you are unable to keep an appointment, we strongly urge you to contact us at least 24 hours in advance if at all possible. In all cases, you must reschedule missed appointments. Failure to keep follow up appointments can result in prolonging the treatment time and reduce the likelihood of achieving the maximum therapeutic effect.

Other options exist to treat, reduce or eliminate myopia and astigmatism. They include; glasses, traditional contact lenses, and refractive surgical procedures. Each modality has its own unique advantages, disadvantages, risks, and benefits. Your doctor has reviewed these options with you during you examination and consultation.

Additional Comments:
________________________________________________________________________________________________________
__________________________________________________________________________________________________

I, the undersigned, fully understand the Corneal Reshaping Therapy Program that has been explained by the doctor, staff member, and/or literature provided by (Practice Name). I have been given the opportunity to ask any questions regarding CRT and I am satisfied with the answers provided.

I agree to enroll in the Corneal Reshaping Therapy program and understand and agree to all of the information indicated in this document.

____________________________________________Date:
Patient Signature or Parent/Guardian Signature for minors
_____________________________________________ Date:
Doctor or Staff Signature (Practice Name)
The cases of: “You’ve got to be kidding!”

Case 1: Pt. seen by OD for dispos. CL fitting, placed on trial pair, one eye immediately began to burn. Pt. called OD that night w/ cont. sx’s, OD told pt. to use cold compresses & RTO in am. Pt. did not show that day Pt. was unhappy w/ recommendation by OD over the phone. Pt. went to ER that night w/ dx of superficial keratitis. No permanent eye or vision damage.
“You’ve got to be kidding!”

**Case 2:** Pt. seen for exam, received routine exam and dispensed reading glasses. Returns 3 days latter wants to return new glasses b/c his eye began to hurt 1 day after the exam & he saw another eye dr. who said he did not need them & told him he had dry eye. He will need to use drops. Pt. claims that pain in eye & dryness was due to being “struck in eye” by 1st OD with the NCT!
“You’ve got to be kidding !”

Case 3: OD wrote a prescription for myopic driving glasses. Pt. filled the Rx and complained of blur and discomfort. 7 f/u visits to the optical were made. Apparently the Rx was incorrectly written as “+” instead of “-”. The claimed consequences of the error were: exhaustion, burning/itching eyes, lack of energy, argumentative personality, and marital strife!
"You’ve got to be kidding!"

Issues at hand

- Frivolous law suits occur
- Practice long enough and you likely will be sued, even for absurd reasons
- Non-medical reasons are often at the source of the law suits (financial, interpersonal, others)
Risk Management Recommendations

- Perform a comprehensive diagnostic evaluation and appropriate follow up
- Utilize standards of care or beyond in diagnosis and management
- Document, document, document in detail
- Educate and inform your patients…and document again!
- Know when to punt and who to punt to!
“Sooner or latter it’s going to get you !… a guide to surviving in the medical legal jungle

Thanks!