Risk comes in many forms
Disclosures

• Dr. Briceland and Linda Harrison have no financial interests to disclose.

• We will not be discussing off-label use

Risks of poorly comanaged patients

• Delay in diagnosis or treatment
• Failure to follow-up
• Patient confusion
• Lawsuits
Communication Breakdown

**Communication**

- 3rd most frequently identified root cause of sentinel events in medical errors (Joint Commission study, 2015)
- At least 50% of these occur during “hand-offs”

Objectives

After participating in this presentation, ophthalmologists will be better able to:

- Develop guidelines for comanagement
- Communicate needed information during patient hand-offs
- Manage patient expectations
Comanagement

• Federal statutory guidelines regarding comanagement fee structure
• Fee guidelines dictate shared care responsibilities

Comanagement

• STATE REGULATIONS
  - State board regulations of professional behavior: medical and optometric
  - Referral behavior and expectations
Case 1: Bilateral Blepharoplasty

- 12/3/15: visit with Ophthalmologist #1:
  - 1-mo hx swollen upper lids; interfered with ability to see/perform at job
  - Medical hx: depression, anxiety, smoker, hypertension, high cholesterol, diabetes, acid reflux, sleep apnea
  - Significant surgical hx: cholecystectomy, knee replacement, hysterectomy

Case 1: Bilateral Blepharoplasty

- 12/3/15: visit with Ophthalmologist #1 (cont’d)
  - Dx: dermatochalasis; bilateral cataracts; increased IOP (24 OS; 22 OD); bilat ocular hypertension
  - Discussed dx with patient: etiology of condition, effect on visual field, risks & benefits of sx.
  - Rec: sleep apnea study; blepharoplasty
Case 1: Bilateral Blepharoplasty

• 12/28/15, eval for bleph, ophthalmologist #2
  – Screening & VF tests
  – Corrected vision 20/25 OD, 20/25 OS
  – Bilateral 3+dermatochalasis, normal eyelids; ocular hypertension; current meds include 81mg aspirin daily
  – Did not measure IOPs
  – Dx: bilateral dermatochalasis upper lids; referred to ophthalmologist #3 for bleph eval

• 1/27/16: consult with ophthalmologist #3.
• Pt. c/o heavy eyelids and blocked vision
• VF test suggests peripheral vision loss due to dermatochalasis
• Noted daily 81 mg aspirin
• Discussed dx with patient
• Rec: bilateral upper eyelid bleph with fat excision
• Asked patient to discuss with her MD whether to halt aspirin pre-op
Case 1: Bilateral Blepharoplasty

- 3/16/16: Pre-op exam; noted patient on aspirin.
- Patient expectations, risks and complications, post-op care, outcomes discussed with patient.
- Reviewed anticoagulant status
- Patient signed consent
- Surgery scheduled for 4/6/16

Case 1: Bilateral Blepharoplasty

- 4/6/16: outpatient surgery
- Pre-op note: no meds taken that day.
- Surgery uneventful
- Post op: some diplopia; no pain
- No aspirin until next day; Erythromycin ophthalmic solution 2x day
- Call surgeon re: excessive bleeding, drainage, any problems
- Post-op appointment scheduled: 4/13/16
Case 1: Bilateral Blepharoplasty

• 4/6/16, evening, patient's neighbor calls; OD on call:
  – profuse bleeding “most of the day” from suture line, OS; lid swollen; nausea and vomiting. Patient could see & open left eye; denied proptosis; no pain
  – Neighbor texted photo of eye to OD
  – OD speaks to surgeon & texts photo

• Dr asks OD to confirm that patient can see, move, and open eye, and no pain; pt confirmed
• Dr asks OD to advise patient to contact if pain, loss of vision, proptosis, increased swelling, inability to move or open eye
• Use ice packs; Phenergan for nausea/vomiting.

• 4/8/16: Patient called & asked to be seen: eye swollen shut and bloody.
  – Seen by OD: no pain; unable to open eye for exam; use ice; sent home
  – OD calls Dr to report findings
Case 1: Bilateral Blepharoplasty

- 4/8/16: Surgeon asks patient to come in ASAP
  - NLP L eye
  - Performs canthotomy and cantholysis; IOP=44 after procedures
  - Diamox; IOP drops to 24
  - No hemorrhage seen
  - Left afferent papillary defect noted
  - Some light and movement from OS
  - Eye drops and Diamox
  - Impression: angle closure glaucoma or potential PION

- 4/9/16: Surgeon sees patient
  - No pain or nausea. Minimal bleeding at canthotomy site. Mild discomfort looking up. Able to open L eye 5mm. IOP 24 OS; pupil defect remained.
  - IOP 24. continue drops, Diamox increased.

- 4/11/16: OD sees patient, NLP OS; IOP 18 OS.
  - Dx: Ischemic optic neuropathy, discussed w/ surgeon.
  - Offered steroids, but patient declined
  - OD called Dr to report findings; texted photo of L eye
Case 1: Bilateral Blepharoplasty

• 4/12/16: exam by same OD.
  – No change, NLP OS. IOP 16 OS
  – OD called Dr to report findings & texted photo

• 4/13/16: exam by Dr.
  – no change; still NLP
  – Discussed ION with patient
  – referred to neuro-ophthalmologist; patient seen same day
  – Dx: unexplained optic neuropathy 2* short posterior ciliary artery compromise from elevated orbital pressure.
  – Diff Dx: retrobulbar optic neuritis
  – RX: steroids x 3 days; orbital MRI; brain MRA

• 4/14—4/27: seen by OD and MD
  – No pain, NLP OS; swelling less OS
  – Patient requested 3rd opinion; referred

• 4/29/16: MRI & MRA.
  – MRI = moderate small vessel ischemic change of uncertain age
  – MRA = possible occlusion distal L mid cerebral artery may represent CVA of uncertain age
Case 1: Bilateral Blepharoplasty

- 4/29/16: patient texts photos to Dr
  - Patient c/o swelling below L eye after crying
  - Dr reassured patient; call if any problems
- 5/4/16: last visit with MD
  - Discussed MRI and MRA findings
  - f/up with PCP
  - Unlikely to regain vision OS
- 5/7/16: Patient at ER, concerned re: infection OS.
  - Dx: periorbital cellulitis OS; IV antibiotics given. Discharged on Keflex.

Case 1: Bilateral Blepharoplasty

- 5/13/16: neuro-ophthalmology consult at Wake Forest
  - Patient claimed she had pain immediately post-op
  - Bleeding began 1.5 hours post-op
  - Dx: ischemic optic neuropathy; irreversible

- Patient lost to follow up

- Damages:
  - Initial demand: 1.2M
Case 1: Bilateral Blepharoplasty

• Issues with care > plaintiff experts:
  – Aspirin should have been stopped prior to surgery
  – Surgery should not have occurred due to aspirin therapy
  – Aspirin caused retrobulbar hemorrhage
  – Post-op care below SOC
  – Vision loss due to:
    • Post-op bleeding that developed into
    • Retrobulbar hemorrhage

Case 1: Bilateral Blepharoplasty

• Issues with care > defense experts:
  – Mixed SOC opinions
  – Post-op care within SOC
  – OK to continue aspirin, if don’t remove excess fat
  – Imaging delayed
  – No evidence earlier intervention would have changed outcome
  – Causation: retrobulbar hemorrhage vs. PION
Case 1: Bilateral Blepharoplasty

• Claim outcome?

A B C D

DISMISS $700K $450K $1.2M

Case 1: Bilateral Blepharoplasty

• Verdict range: 700-900K, Settlement range 600-750K
• Surgeon dismissed
• Claim against group/entity
Risk Management Principles

• Challenges when multiple providers involved
• Documentation
• Oral consent for comanagement with OD
• Protocol for post-op calls from patients
• Surgeon’s responsibility to patient

Case 1: Bilateral Blepharoplasty

• Claim outcome?
• A  B  C  D

$450K
Case 2: Comanaged LASIK

- 38 year old myopic female with astigmatism presented for LASIK evaluation
- Optometrist noted dry eyes
- Punctal plugs declined by patient

Two days later, bilateral LASIK performed without complications. No pre-op evaluation by surgeon of dry eyes.

Postoperative day 1:
  - Seen by optometrist.
  - C/o dry eyes and poor vision.
Case 2: Comanaged LASIK

- PO day 7, patient c/o dry eyes and poor vision; using artificial tears, not driving.
- PO day 13, patient c/o dry eyes and poor vision; using artificial tears every 30 minutes.
- 4 weeks post-op, c/o dry eyes and poor vision; still using artificial tears.
- 3 months post-op, c/o dry eyes and poor vision; lower eyelid punctal plugs.

Case 2: Comanaged LASIK

- 5 ½ months post-op: c/o dry eyes and poor vision; using artificial tears.
- 6 months post-op: c/o dry eyes and double vision; upper eyelid collagen punctal plugs
- 6 ½ months post-op: refuses to be seen by O.D.; demands to be seen by surgeon.
Case 2: Comanaged LASIK

- **Seven months** post-op, surgeon examines patient:
  - Dry eyes with double vision.
  - Reinserts collagen punctal plugs.
  - Returns patient to comanaging optometrist without long-term plan.

Case 2: Comanaged LASIK

- Two weeks later, patient c/o dry eyes and poor vision; using artificial tears.
  - sent to a new comanaging O.D.
- Three weeks later (8 ½ months post-op)
  - c/o dry eyes and poor vision –
  - planned visit with surgeon – **but did not occur**
Case 2: Comanaged LASIK

• Six weeks later:
  – c/o dry eyes, poor vision; not driving or working
• Three weeks later (10 ½ months post-op):
  – c/o dry eyes and poor vision
  – *declines further follow up* (bad sign).

• Last visit BCVA OD 20/70  OS  20/80

Case 2: Comanaged LASIK

• **Patient files suit**

• Plaintiff expert:
  – needed better preoperative evaluation of tear film
  – detailed informed consent

• Defense expert:
  – dry eye known complication
Case 2: Comanaged LASIK

• Poor communication with patient regarding:
  - Persistent dry eyes
  - Response to treatment
  - Plan and prognosis

  Poor communication with comanaging optometrist

Case 2: Comanaged LASIK

Plaintiff allegations:
• No initial evaluation by surgeon
• No inspection of care
• Minimal active intervention post operatively
• Poor Outcome
Case 2: Comanaged LASIK

- Claim outcome?
- A   B   C   D

DISMISS   $50K   $250K   $500K

Case 2: Comanaged LASIK

- Claim outcome?
- A   B   C   D

$250K
Settled 1st day of trial
Risk Management Principles

• Independent pre-op eval by surgeon
• F/up of documented concerns
• Oral informed consent re: comanagement
• Protocol with comanaging OD

Case 3: Comanaged Cataract Surgery

• Cataract surgery and IOL in 80 y/o male by MD
• PO day 1: No complications; care transferred to OD
• PO day 6: seen by comanaging OD; c/o pain. Increased steroids. Return 2 weeks
Case 3: Comanaged Cataract Surgery

• Two days later (PO day 8), patient’s daughter asks surgeon to see her father. Surgeon diagnoses endophthalmitis and starts antibiotics.

• Next day, improved, so surgeon referred patient back to OD in 2 days
  – Recall same OD had missed diagnosis

Case 3: Comanaged Cataract Surgery

• Next day (PO day 10), patient called surgeon to report pain.
• Told to use Motrin and eye drops.
• Called back later same day to report improvement.
• Told to follow-up with OD, who saw him that day.
Case 3: Comanaged Cataract Surgery

- PO day 15: to ED with c/o poor vision and pain – retained cortex, **increase steroids**.
- Seen that day by optometrist who noted improvement; no dilation.
- PO day 17, saw retina specialist, VA HM, pseudomonas endophthalmitis.
- Final outcome: VA HM

Case 3: Comanaged Cataract Surgery

- **Patient files suit**
- Alleges surgery contraindicated with history of blepharitis
- Delay in diagnosing endophthalmitis by OD
- Negligent management of endophthalmitis by ophthalmologist
Case 3: Comanaged Cataract Surgery

**DEFENSE**
- Poor communication between surgeon and optometrist.
  - Initial complaints misdiagnosed
  - F/U complaints and ER visit
- Surgeon should have reviewed f/u plan – dilation.
- Surgeon should have followed patient with endophthalmitis

**Plaintiff’s allegations:**
- Poor communication
- No active or continued dialogue
- No comanaging protocol
- Poor oversight
Case 3: Comanaged Cataract Surgery

• Claim outcome?
  A  B  C  D

DISMISS  $75K  $250K  $500K

Case 3: Comanaged Cataract Surgery

• Claim outcome?
  A  B  C  D

$75K  Oph.  $79K  OD
Risk Management Principles

• Vetting external comanaging ODs
• Establish protocol and expectations
• Written consent by patient for comanagement
• Physician responsibilities

Case 4: Comanaged Glaucoma

• 60 year old female with DM evaluated by OD in group
• Diagnosis: Cataracts, diabetic macular edema, rubeosis iridis, and narrow angles.
• Refer to M.D. in group in 2 months.
Case 4: Comanaged Glaucoma

• Patient no show for 2 month follow-up.
• MD indicates f/u on “next available date”
• Four months after initial visit, patient presents emergently with pain
• VA LP, IOP 76 OS.
• MD notes neovascular glaucoma, angle closure, PDR, hyphema.

Case 4: Comanaged Glaucoma

• Expert Opinions:
  - MD and OD below SOC
  - Optometrist should have referred immediately
  - Physician should have reviewed chart and seen immediately after missed appointment
Case 4: Comanaged Glaucoma

• Claim outcome?
• A B C D

DISMISS

$50K

$250K

$500K

$250K paid by OD
MD dismissed
Risk Management Principles

• Office protocol for no-shows
• Assure competence and training of ODs
• Set expectations for ODs in group
• Active dialogue and participation in care
• Review and inspect care

Time Check...
One more case?
Case 5: Glaucoma-Retina

- **GLAUCOMA EVALUATION**
  - 66 y/o female
  - 25-year hx advanced uncontrolled chronic angle closure glaucoma
  - 10 degree islands

- Trabeculectomy performed OS
- PO day 4: IOP mid teens
- A/C formed but diffusely shallow
- Referred to retina with ? diagnosis of aqueous misdirection (malignant glaucoma)
Case 5: Glaucoma-Retina

- **RETINA EVALUATION**
  - VA 20/30 OD, CF OS
  - IOP 14 OD, 16 OS
  - Filtered eye (OS) diffuse bleb
  - Anterior chamber moderately shallow
  - Ultrasound: Diagnosis ? choroidal detachment

Case 5: Glaucoma-Retina

- **RETINA**
  - Lensectomy/vitrectomy to reverse aqueous misdirection
  - Operative note: found choroidal detachment
  - Surgery stopped due to suprachoroidal hemorrhage
  - **Final outcome**: Enucleation
Case 5: Glaucoma-Retina

Plaintiff’s allegations:
• Glaucoma specialist (non-OMIC) and retina specialist (OMIC) BOTH SUED for misdiagnosis and unnecessary surgery

Case 5: Glaucoma-Retina

• PLAINIFF EXPERT CONTENTIONS:
• Glaucoma made wrong diagnosis: problem was over-filtering
• Retina should have known that choroidal detachment common after filtration surgery. Performed unnecessary surgery
• Surgical complications led to enucleation
Case 5: Glaucoma-Retina

• **RETINA DEFENSE EXPERT OPINIONS:**
  • Initially supportive, later felt wrong diagnosis by glaucoma expert
  • Sympathetic on deferral to glaucoma expertise, and desire to save vision
  • If choroidal detachment, need to wait due to bleeding risk
  • “…caught between a rock and a hard place”

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Case 5: Glaucoma-Retina

• **OTHER PROBLEMS:**
  • Missing operative report
  • Letters to glaucoma had information and dates inconsistent with other records
  • When record found, stated pre-op deep anterior chamber, mild choroidal detachment
  • Credibility issues
Risk Management Principles

- Retina relied on Glaucoma’s dx
- Dx inconsistent with Retina’s exam
  - Insufficient assessment?
- Poor documentation of events
- Missing op report
- Credibility and Defensibility

Case 5: Glaucoma-Retina

- Claim Outcome?
  
  A  B  C  D

  $200K
  (Settlement)
  Retina
  Unknown for Glaucoma
Risk Management Summary

- The independent duty of the ophthalmologist
- Vet the OD and establish guidelines
- Informed consent from patient (oral vs. written)
- Hand-offs: internal and external
- As always: thorough documentation
- Office protocols:
  - no-shows, post-op complications

- OMIC document

- AAO document
  - https://www.aao.org/ethics-detail/guidelines-comanagement-postoperative-care

Thank You!