

Ophthalmic Risk Management Digest

OMIC DIGEST

Minor Distractions Lead to Major Problems in the OR

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It is well known in aviation circles that minor distractions are often the cause of major airline accidents. A perfect example is the December 29, 1972 accident of an Eastern Airline L-1011 with 176 passengers on board that casually and subtly descended 2,000 feet before crashing into the Everglades while the captain and copilot, sitting in their respective seats, and a third crew member tried to troubleshoot a gear warning light malfunction, all the time ignoring audible and visual instrument warnings that the aircraft was about to crash. The aircraft had been forced to break off its approach to Miami International Airport after the nose gear light failed to illuminate, raising concerns about whether the gear was properly lowered for landing. While in a holding pattern at 2,000 feet above Everglades National Park, the captain bumped his control column, leading to the disconnection of the autopilot. With the attention of all three crew members focused on the landing gear and the extinguished light, the aircraft descended unnoticed into the ground. One hundred passengers and crew members perished.

How could such a thing happen, and how does this incident apply to OMIC's experience with claims involving seemingly simple or minor surgical procedures? Attending to a failed nose gear warning light should not result in the death of 100 people. Likewise, anesthetic injection into a lower eyelid for chalazion removal should not result in penetration of the globe, retinal detachment, and loss of the eye. Yet, this is what happened to a 35-year-old man, who presented with a chalazion in the left lower eyelid. Although the procedure was noted to be "without complication," the patient returned to the office the following day with complaints of severe left eye pain and visual loss. The patient was referred to a retinal surgeon, who discovered a large corneal abrasion, an inferotemporal chorioretinal scar, and an adjacent retinal defect. Despite several surgeries, the patient's vision never improved beyond 20/300; the case was settled during pre-trial mediation for \$250,000.

When such an outcome occurs, one can usually point to a breakdown in surgical technique (technical performance),

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MESSAGE FROM THE CHAIRMAN



I am very pleased to announce that the OMIC Board has approved a rate decrease for all professional liability policyholders in 2007. Premiums will decrease an average of 5.2%, with insureds in a number of states receiving as much as a 7% decrease. Of OMIC's 3,675

insureds, 65% will see their 2007 premiums drop between 5% and 7%. How much premiums will decrease in any particular state is based on a number of actuarial indications that take into account past ophthalmic claims experience, the medical malpractice climate, and the verifiable effect of tort reform legislation. More specific information about the rate decrease in each state will be provided in a letter to OMIC insureds this fall.

OMIC began reducing insurance costs earlier this year when all policyholders received a credit toward their 2006 renewal premium, and we are one of the first carriers to announce a premium decrease for 2007 in response to a more stable medical malpractice insurance market. As a mutual insurance company, it has always been OMIC's philosophy to reinvest profits back into the company and, when actuarially supported by our claims experience and operational

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distraction, or inattention of the surgeon immediately prior to or at the time of the incident, or complacency among the surgical team because the procedure is “simple” or “minor.” The adage, “fly the airplane first, and then solve the emergency” applies to surgery as well. To put it in surgical terms: focus on the patient, the surgical field, and the task at hand. Don’t be distracted by nearby events. Intuitively, we know from experience that surgeons prepare for, plan, and execute complex or risky cases with great attention to detail. The surgeon is focused on the difficult and challenging technical aspects of the case. The surgical team feels the tension and pressure to perform with a high level of skill. The OR is silent. The surgical team avoids irrelevant discussions that might divert the surgeon’s attention from the task at hand. This is not unlike the situation in the cockpit when pilots are circumnavigating thunderstorms and landing in low visibility. As in surgery, everyone involved has a stake in the outcome and everyone’s attention is directed at bringing the flight (or surgery) to a successful conclusion.

The Dangers of Complacency

We recognize, however, that it is human nature to let one’s guard down in the office treatment room when performing straightforward or routine treatments and even in difficult cases once the critical portions of the case are over. Complacency (and therefore surgical or technical errors) is more likely to develop during “minor” or “routine” cases where the risk is seemingly low and the technical aspects of the case are simple or straightforward. Also, in difficult cases, there is usually good chart documentation of the complex nature of the case, and the risks of the procedure are spelled out in the surgical consent form, often in the surgeon’s own handwriting. In the

case of “minor surgery,” the surgeon may pop into the room momentarily to inject the eyelid and return 15 or 20 minutes later and hastily remove an eyelid papilloma or drain a chalazion. If the surgeon’s attention is diverted by a telephone call, or the patient is startled by the surgeon’s beeper just as the needle penetrates the skin, inadvertent, sudden movement may lead to ocular penetration with disastrous results. Because the case is “minor in scope,” there may or may not be a signed consent. Some physicians require only oral consent for minor cases handled in a treatment room setting. The surgeon or nurse may overlook the importance of sending a specimen to the pathology laboratory because the lesion “appears benign.” In other offices, there is no requirement to dictate or even document the performance of “minor” surgical procedures. There may be no written instructions given to the patient at discharge. The patient may be discharged to drive home alone with one eye patched. While everyone recognizes this is not the ideal way to practice, the reality and pressures of a busy clinic or office is the background for distractions that lead to incidents, suits, and even large malpractice awards. It is not until an error occurs that the lack of a signed consent form becomes the key (missing) document in a malpractice case.

These very tendencies towards complacency and inattentiveness were identified years ago as a major contributing cause of aircraft accidents and led air carriers and the FAA to adopt the “sterile cockpit” rule. By regulation, there can be no extraneous or irrelevant conversation in the cockpit by the aircrew when flying lower than 10,000 feet above ground level. The goal is to have the flight crew totally focused on flying the aircraft during the critical phases of flight. This lesson can be applied to the operating room as well.

“Minor” Oculoplastic Cases

A review of OMIC oculoplastic claims since the company opened for business almost 20 years ago (Table 1) reveals some interesting statistics that reinforce the need to maintain diligence during “minor” eyelid surgery. Surprisingly, some of the largest awards in oculoplastic surgery were those involving such “minor” procedures as eyelid biopsy, papilloma or cyst removal, and punctal cautery. The single largest oculoplastic award of \$975,000 was for visual loss occurring during excision of a chalazion. In fact, of the \$8 million paid by OMIC for oculoplastic claims over 19 years, \$1.27 million was paid for incidents that occurred during removal of chalazia (Table 2). Loss of vision due to penetration of

TABLE 1
OMIC PAYMENTS BY
PROCEDURE—OCULOPLASTICS

Conjunctiva	\$	10,000
Major eyelid surgery	\$	12,500
Orbital infection	\$	20,000
Socket	\$	26,500
Lacrimal	\$	46,500
Brow forehead lift	\$	65,000
Orbital tumor	\$	183,310
Minor eyelid surgery	\$	270,000
Eyelid cancer	\$	350,000
Graves' related	\$	500,000
Orbital fracture	\$	857,965
Laser resurfacing	\$	971,250
Chalazion	\$	1,271,144
Ptosis	\$	1,373,000
Blepharoplasty	\$	2,066,277

Note: Figures reflect total indemnity payments and do not represent the number of claims or the amount paid per claim. Some procedures (facelift, endoforehead lift) have only recently been covered by OMIC.

the globe with retinal detachment, corneal perforation, and flash fires leading to scarred and poorly functioning eyelids are not expected outcomes of chalazion surgery and such cases are almost impossible to defend. The goal for all should be prevention of such maloccurrences since little can be done after the fact to satisfy a patient or family other than to make financial restitution and settle the claim. Even that is not a satisfactory resolution because the patient has to live forever with severe or total vision loss.

OMIC has paid out \$710,000 for claims involving five fires in the surgical setting. Four of the five preventable fires occurred in a treatment room or ASC setting during “simple” or “minor” surgical

2. Adopt the sterile cockpit rule—avoid extraneous conversation and don’t allow distractions to creep into the operating or treatment room. Turn off your beeper and instruct your staff not to call into the treatment room during surgery.
3. Do not allow yourself to become rushed because of office or waiting room pressures.
4. Let the patient know what to expect so he/she is not surprised into making a sudden or inadvertent move.
5. Check for allergies before giving an injection or using oral/intravenous drugs in the treatment room.
6. Inject anesthetics slowly and ensure the eyelid or eye is totally anesthetized to minimize patient movement due to sudden or unexpected pain.

10. After discussing the procedure with the patient, always have the patient sign a surgical consent form prior to any surgical procedure.

11. Document each treatment room procedure with a dictated or handwritten operative note that conforms to the current standard for surgical documentation.
12. Give written postoperative or wound care instructions to patients prior to discharge, even in the treatment room setting.
13. Be sure the patient is discharged to the care of a competent adult, particularly if there is temporary visual impairment or mental compromise due to sedation.
14. Obtain and follow OMIC’s guidelines, “Office-based Surgery for Adults,” which can be found in the **Risk Management Recommendations** section of www.omic.com. These recommendations are applicable to surgery in an ambulatory surgical or hospital OR setting as well as in the treatment room.

The same principles apply to major ophthalmic cases; however, errors due to inattention or distractions are less likely to occur because of the surgical setting and absence of office pressures in the treatment room. Nevertheless, it is easy to let one’s guard down towards the end of the case once the stress of the actual surgery is over. Instruments are dropped, packing is not removed, and patches are inappropriately applied in the rush to get the patient to the recovery room. If the surgical team adopts the approach that the case is not over until the patient is safely in the post-anesthesia care unit, mistakes and the chance for adverse events can be minimized. Again, an airline corollary: the flight is not over until the aircraft pulls up to the gate and the passengers disembark!

TABLE 2 OMIC CLAIMS EXPERIENCE— CHALAZION	
10 Closed Claims	
4	no indemnity paid
2	less than \$10,000 paid
2	between \$10,000 and \$25,000 paid
1	\$250,000 paid
1	\$975,000 paid

TABLE 3 OMIC CLAIMS EXPERIENCE— FIRE IN OR SETTING	
5 Closed Claims	
1	\$10,000 paid
1	\$25,000 paid
3	between \$100,000 and \$430,000 paid

procedures (Table 3). One such case is presented in this issue’s Closed Claim Study, while the Risk Management Hotline focuses on preventing and managing surgical fires.

Risk Management Tips

How can a physician alter behavior to minimize the risk of an inadvertent error during surgery? Here are some suggestions:

1. Remember that any surgical or diagnostic procedure carries risk. Instruct your staff and make a personal commitment to approach every surgical procedure as a major case. Avoid the term “minor procedure” when talking to patients. Use “straightforward” instead.

7. Apply topical anesthesia to the conjunctiva before making a transconjunctival injection to anesthetize the eyelid or conjunctiva for surgery. A comfortable patient is less likely to move inadvertently.
8. Learn to use regional nerve block techniques while working on eyelids, eyebrows, and cheeks. Infraorbital, anterior ethmoidal, supratrochlear, infratrochlear, lacrimal, and supraorbital nerve blocks allow a surgeon to work with the patient’s anatomy totally anesthetized and free of pain.
9. Use cornea or globe protection for eyelid procedures (metal corneal protective shields).