Closed Claim Study

Negligent Telephone Care of Postoperative Patient

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Allegation

Delay in diagnosis and treatment of retinal detachment following cataract surgery.

Disposition

Defense verdict at trial.

Case Summary

A 58-year-old female with lattice degeneration had uncomplicated cataract surgery. Three months postoperatively, the patient called the surgeon to report seeing branches and black spots of one day duration and was told to come in. She denied seeing flashing lights. BCVA was 20/25, and a dilated fundus with scleral depression examination of the right eye revealed vitreous hemorrhage and floaters. The macula and peripheral retina were flat without holes, tears, or evidence of retinal detachment. The ophthalmologist prescribed bed rest (with the head of the bed elevated at 30 degrees) and advised the patient to follow up in 1 to 2 weeks or sooner if she developed increasing floaters, photopsia, or a veil/curtain formation.

The patient said she called the office four days later to report that she could barely see through a dark bubble. She claimed to have spoken to the receptionist, who consulted with the ophthalmologist, and was told not to worry. There was no documentation of the call. In deposition, the insured recalled being told only that the patient wanted to know when the floaters would resolve. She believed that she either asked the receptionist to call the patient back and verify the lack of new symptoms or that she called the patient herself. Five days later, the patient called again and said she was coming in. At the visit, she reported fluctuating vision and was noted to have a VA of CF, with both a horseshoe tear and a macula-on retinal detachment in the superotemporal quadrant. The insured spoke with a retinal specialist, who agreed to see the patient the next day; the call was not documented and the specialist had no recall of the conversation. When the patient was seen the next day, the detachment had progressed to macula-off. The patient had a scleral buckle, vitrectomy, air/fluid gas exchange, and endolaser surgery. At the time of trial eight months later, the retina was still attached, with vision pinholed to 20/60; the patient reported multiple visual problems.

Analysis

Plaintiff experts focused on the increased risk of retinal detachment in patients with lattice degeneration and cataract surgery. They doubted the ability to visualize the retina in the presence of vitreous hemorrhage and criticized the delay in referral to the retinal specialist then and when the detachment was diagnosed. Defense experts supported the insured's examinations and treatment; moreover, they felt strongly that an experienced cataract surgeon, who had explicitly warned the patient about retinal detachment, would never ignore reports of a dark bubble. The lack of documentation, especially of the phone calls with the patient and the retinal specialist, became the focal point of the trial. Jurors who returned a defense verdict later explained that the plaintiff lost credibility when she refused to pursue the recommendations of a blind vocational rehabilitation expert. Nonetheless, they had sharp criticism for the insured's call screening process and failure to document telephone care.

Risk Management Principles

Telephone screening of eye complaints, especially in postoperative patients, is an extremely risky aspect of ophthalmic practice and a regular feature of malpractice lawsuits. Physicians need written protocols, including contact forms that prompt them and their staff to ask crucial questions and document the responses, as well as guidelines to determine when the patient needs to be seen. Such sample forms and protocols are available online and from OMIC's Risk Management Department (see cover article). The physician's screening process is intended to gather the information necessary to develop a differential diagnosis that includes the worst case scenario for the patient's presentation. In this case, the ophthalmologist clearly identified the risk of retinal detachment, but she could have been more proactive in managing it by making an early referral to a retina specialist to verify her examination in the presence of hemorrhage and by scheduling frequent follow-up visits before the patient left her office.