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Ophthalmic Risk Management Digest
OMIC DIGEST

Ocular Anesthesia Claims: Causes and Outcomes

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Ocular anesthesia presents challenges for both the ophthalmologist and anesthesiologist. Each must address patient anxiety about eye surgery, including concerns about eye pain or movement during surgery, and possible vision loss. When determining the appropriate anesthesia to use, physicians must take into consideration possible multiple medical comorbidities in elderly patients and the particular anesthesia risks for pediatric patients, especially those who may be premature or have congenital syndromes. Following application of the anesthetic agents, they may need to manage intraocular pressure or respond to cardiovascular events precipitated by oculocardiac reflexes.

OMIC recently conducted a review of claims related to anesthesia and sedation in order to identify issues that can be addressed through proactive risk management. The results of this study are summarized in this article and in an online course. The study was a retrospective analysis of 18 years of OMIC claims experience (1987-2005). While OMIC's database includes incidents reported by physicians on a precautionary basis, only actual malpractice claims – defined as written demands for money and lawsuits – were included. Cases were located by searching for anesthesia- and sedation-related words in allegations and through codes assigned to these procedures, such as retrobulbar or peribulbar injections. Therapeutic injections were excluded. At times, information was available only from case summaries, not from medical records. As these results show, very few of the thousands of patients who undergo ophthalmic procedures sue their provider for professional negligence in the administration of anesthesia or sedation.

Out of 2,474 OMIC claims during this 18-year period, only 78, or 3%, were related to anesthesia and sedation. Of the 65 closed anesthesia/sedation claims, 43, or 66%, were closed without any indemnity payment to the plaintiff. Claims resolved without any payment to the plaintiff (former patient) for several reasons: (1) the claim was not pursued by the plaintiff,

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MESSAGE FROM THE CHAIRMAN

OMIC has been fortunate over the years to have achieved balance and diversity among its Board and committee members. A few of the company's original founders remain involved in OMIC's governance, providing institutional memory and an understanding of what is necessary to keep the company on an even keel. Newer Board and committee members, meanwhile, infuse the company with energy, enthusiasm, and a spirit of innovation. Both play crucial roles in OMIC's success.

Recent scandals have heightened awareness of corporate governance and put in sharp relief the importance of properly and ethically managing a company. Although OMIC is a relatively small insurance company, it is no less regulated and scrutinized than larger financial corporations. The company's ultimate goal is straightforward: defend and indemnify insured members who are sued for malpractice and invest members' premiums wisely so there are sufficient reserves to do this. This necessarily involves many highly skilled

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often after OMIC denied it for lack of merit; (2) the physician was dismissed from the lawsuit through legal action; this was most common when he or she did not administer the anesthesia; or (3) a jury, medical review panel, or arbitrator supported the physician's care.

In 22 of the 65 closed cases, the plaintiff was awarded money as a result of settlements or plaintiff verdicts at trial or arbitration. While the frequency of anesthesia claims is low, both the percentage of claims resulting in payments and the severity of the indemnity awards were higher than OMIC's overall claims averages (see **Table 1**). Defense costs for these 65 closed claims, however, were somewhat lower than OMIC's overall average ($34,574 vs. $39,324) and median ($21,688 vs. $26,223) cost per case.

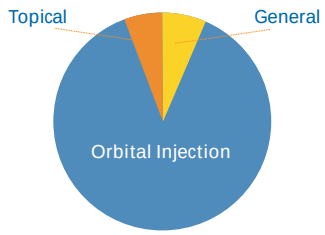
TABLE 1
ANESTHESIA OVERALL

	INDEMNITY	INDEMNITY
High	$ 999,999	$ 1,800,000
Low	$ 5,500	$ 500
Average	$ 202,993	$ 131,960
Median	$ 150,000	$ 75,000
Total	$ 4,446,853	$55,360,884
% Payment	34%	21%

Types of Anesthesia Resulting in Claims

Complications of orbital injection anesthesia accounted for the overwhelming majority of anesthesia/sedation-related claims against OMIC insureds (69 claims), while general and topical anesthesia accounted for only 5 and 4 claims, respectively. Sedation was an issue in 5 of the 69 orbital claims. Retrobulbar anesthesia was administered in 49 cases: 32 times by ophthalmologists, including one ophthalmology resident, 14 times by anesthesiologists, and 3 times by Certified Registered Nurse Anesthetists. Of the 16 peribulbar blocks, 9 were given by eye surgeons and 6 by anesthesiologists. The only O'Brien block was injected by an ophthalmologist; the type of orbital anesthesia was not specified in 3 claims. Of note, there were no claims resulting from sub-Tenon's blocks.

TYPES OF ANESTHESIA RESULTING IN CLAIMS



Complications of Ocular Anesthesia

The complications resulting from retro- and peribulbar blocks in the OMIC cases correlate closely with those reported in the medical literature[1,2] (see **Table 2**). Perforation was the most likely complication, followed by cardiovascular events and hemorrhage. Sedation-related problems were the primary issue in two settled claims. In one case, the plaintiff alleged that her pain and anxiety were inadequately controlled, resulting in a $450,000 indemnity payment on behalf of the ophthalmologist. In the second, the ophthalmologist ordered a nurse to administer sublingual Procardia and oral Valium to an elderly patient, who suffered a series of strokes after she was discharged with a blood pressure significantly lower than upon admission. Neither the ophthalmologist nor the nurse was aware of the "black box" warning associating sublingual Procardia with severe hypotension and stroke. The ophthalmologist and ambulatory surgery center each contributed $375,000 toward the settlement.

TABLE 2
ORBITAL ANESTHESIA COMPLICATIONS

Perforation	28
Cardiovascular event	10
Hemorrhage	8
CRAO	4
Corneal abrasion	3
Diplopia	3
Pain	3
Optic nerve damage	2
Seizure	2
Vision loss	2
Brain stem anesthesia	1
Numbness	1
Vitreous prolapse	1

In all 4 closed general anesthesia claims, the ophthalmologists were dismissed from the lawsuits despite complications that included adult respiratory distress syndrome, intraoperative choking with a postoperative CVA, and death due to aspiration. The authors do not have information on the outcome for the anesthesia providers in these claims. Failure to control pain and/or movement was the allegation in 2 open topical anesthesia claims, while inadequate pain relief allegedly led to hypertension and hemorrhage in 2 closed topical anesthesia claims. In the closed cases, a cataract surgery claim closed without payment, while a combined cataract/trabeculectomy case settled for $150,000. Both plaintiff and defense experts criticized the use of topical anesthesia for trabeculectomy and felt surgery was not indicated in the first place, as the patient did not have glaucoma.

Standard of Care Was Met But Other Issues Arose

Eye surgeons who meet the standard of care expect to successfully defend

their treatment. Nonetheless, in 6 of the 22 paid indemnity cases, the plaintiff prevailed even though OMIC's Claims Committee, claims associates, and defense experts were fully supportive of the care provided. Three of these cases were settled at the request of the insured physician due to the ophthalmologist's health issues, nervousness, or desire to compensate the patient for lost wages. In another, an unwitting dictation mistake concerning the timing of a perforation following a retrobulbar unduly complicated the defense. In 2 instances, the plaintiff attorneys made side deals with the anesthesia providers just before trial in order to pressure the ophthalmologists to settle, even though the anesthesiologists were felt to be responsible for the plaintiffs' injuries. The anesthesiologist was dismissed in one of these cases and the anesthesiology group made a nominal payment, leaving the ophthalmologist as the sole defendant. After similar maneuvers in the other case, a new theory of negligence was introduced against the ophthalmologist. When the medicine is complicated, the venue is plaintiff-oriented, the outcome is poor, and the ophthalmologist is the only defendant left, a settlement within policy limits can be a prudent move to protect the insured's personal assets.

Concerns About Care

During the informed consent discussion, ophthalmologists warn patients about the complications associated with anesthesia and the patient's particular surgery. If a complication occurs but is promptly recognized and appropriately managed, the outcome is considered to be a maloccurrence rather than malpractice or negligence. A single concern about an aspect of care can usually be explained to a jury. Multiple concerns about care still do not constitute negligence, but they can greatly strengthen a plaintiff's case and persuade a jury to give the plaintiff, rather than the physician, the benefit of the doubt. Three of OMIC's 22 cases that closed with indemnity payments fall into this category. In the first case, lack of indications for surgery, failure to communicate to the anesthesiologist the difficulties of a wide and long eye, and criticisms about the lack of documentation of a staphyloma led to a settlement. In the second case, a settlement was reached because there was no documented consent, the cause of the injury to the optic nerve could not be ascertained, and the postoperative management was subpar. Questionable indications for a second surgery coupled with scanty documentation and a difficult venue led to a settlement in the third claim.

Negligence

Physician negligence was felt to be the cause of the plaintiff's injury in 13 of the 22 cases that resulted in an indemnity payment. **Table 3** indicates the point in the care process at which the skill, judgment, or expertise of the insured was not that of a reasonably prudent ophthalmologist, which is generally the standard experts use when evaluating a case.

Lawsuits may be mitigated by applying risk management principles at every step of care, from determining the proper procedure to making appropriate care decisions after maloccurrences, and documenting that care clearly and completely. Careful informed consent discussions about anesthesia choices, clear communication with other providers, and an empathetic response to patient concerns and questions can also significantly reduce the likelihood of claims. Please see the document "Ophthalmic Anesthesia Liability" at www.omic.com.

Finally, while the actual choice of anesthesia or its administration was less frequently a concern, physicians should consider substituting sub-Tenon's for orbital injection anesthesia when appropriate, given its significantly lower risk profile. OMIC's online "Ophthalmic Anesthesia Liability" course, nearing completion, will feature a video demonstrating this technique.

TABLE 3
INCIDENCE OF RISK ISSUES INVOLVING NEGLIGENCE
(more than one may apply)

Negligent management of complication: • After-hours telephone screening • Failure to refer to subspecialist • Poor control of IOP	7
Documentation issues concerning: • Informed consent • Findings • Errors • Decision-making process • Altered records	6
Surgery not indicated	4
Negligent choice of anesthesia and inadequate control of: • Pain • Movement • Anxiety	3
Negligent administration of orbital injection: • Oxygen mask hindered view while injecting • Injected into wrong muscle • Injected into wrong eye	3
Negligent preoperative assessment of: • Patient on Coumadin • History of hemophilia	2
Negligent choice of anesthesia provider to administer and monitor sedation	2
Negligent communication with anesthesia provider	1

1. Stead SW and Bell SB, Focal Points: Ocular Anesthesia, The Foundation of the American Academy of Ophthalmology, March 2001: Vol. XIX, No. 3.

2. Anesthesia Alternatives for Ocular Surgery, American Academy of Ophthalmology, 2001.