Closed Claim Study

Failure to Treat and Refer Patient with Diabetic Retinopathy

By Ryan Bucsi, OMIC Senior Litigation Analyst

ALLEGATION

Failure to refer patient to a retinal specialist and failure to perform a YAG in a timely manner.

DISPOSITION

Case settled for $1,275,000.

Case Summary

A young insulin-dependent diabetic on dialysis presented to an OMIC insured complaining of blurry vision. Upon initial examination, the patient was best corrected to 20/80 OU and diagnosed with bilateral cataracts. The insured performed cataract surgery on both eyes and vision improved to 20/30 OU. The patient was subsequently examined by the group's employed optometrist, who documented disc neovascularization and noted that the insured ophthalmologist also examined the patient. This turned out to be the only record of the ophthalmologist's exam that day. He later told defense counsel he did not agree with the optometrist that the patient had disc neovascularization; however, neither his exam nor decision-making process was documented. The same optometrist examined the patient one month later and documented a stable fundus.

During this time, a non-OMIC insured ophthalmologist wrote a letter on the patient's behalf to the County Health Department's Division of Disability Determinations recommending a YAG laser capsulotomy to evaluate the fundus for diabetic retinopathy. A copy of this ophthalmologist's letter was sent to the insured's group, but no action was taken. In fact, the patient was again examined by the group's optometrist and advised to return in four months. The patient did not return until eight months later, by which time vision had deteriorated to NLP OD and CF OS. A different OMIC insured in the same practice diagnosed a questionable retinal detachment OS and performed a paracentesis. He prescribed drops and scheduled a YAG for the following week, but the procedure was later postponed pending approval of the patient's eligibility by the Division of Blind Services. The second insured finally performed the YAG two months after determining it was needed. He referred the patient to a retinal specialist, who performed two vitrectomies and retinal detachment repairs; however, massive bleeding led to complete visual loss OU.

Analysis

Defense experts voiced some support for each insured's care but also criticism. They noted that the first insured did not follow up after the cataract surgery even though this patient was highly likely to develop diabetic retinopathy. The second insured ophthalmologist, after diagnosing retinal detachment, did not properly treat it or perform the YAG or refer the patient in a timely manner. Plaintiff counsel alleged that the group delayed this patient's care due to a dispute over a $15 balance which the patient claimed she could not afford. Since the patient had lost her Medicaid coverage, the County Health Department referred her to the Division of Blind Services to arrange payment for the YAG but not in a timely enough manner. Defense counsel for both insureds felt that the payment issues could alienate jurors and potentially sway them to return a verdict well in excess of the $1 million policy carried by each insured. The insureds demanded that OMIC settle the case within policy limits. The first insured's case settled for $700,000 and the second for $575,000 for a total of $1,275,000.

Risk Management Principles

The primary risk in this case was not lack of physician knowledge or skill. Familiar with the natural history of diabetes and aware that the disease had already led to renal failure requiring dialysis, both ophthalmologists and the optometrist knew the disease would manifest in the eyes eventually. No one kept this knowledge in mind, however, when treating this patient. Instead, "systems" issues appear to have interfered with proper care. The optometrist noted the early signs of retinopathy, but backed off when the ophthalmologist, who was above him in the group hierarchy, did not agree with the assessment. Both ophthalmologists were employees of the practice and may not have been in a position of authority to determine who should be assigned to high risk patients or to effectively challenge financial policies that delayed acute care. The group's policies and structure hindered any one provider's ability to take ownership of the patient and follow the care through to completion. In hindsight, it is easy to acknowledge that emergency treatment should never be delayed due to issues with an account balance or the patient's inability to pay and that ophthalmologists have a duty to advocate on behalf of the patient.