Closed Claim Study

Personal Relationship with a Physician-Patient Clouds Judgment on Documentation

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ALLEGATION

Failure to educate patient on the symptoms and urgency of treatment for a retinal detachment.

DISPOSITION

The case was settled for $300,000 at mediation.

Case Summary

An OMIC insured examined a physician colleague he had known professionally for several years. The examination took place in the insured's office. Indirect ophthalmoscopy revealed a "definite small vitreous hemorrhage," but no holes or tears were noticed OS. A follow-up examination was scheduled for three weeks. Exactly two weeks after the initial exam, the patient was out of town when he experienced a progressive decrease in vision and total vision loss OS. He did not report the vision loss until six days later when he returned to the insured's office one day prior to his scheduled appointment. The patient was seen by a partner of the OMIC insured, who diagnosed a retinal detachment involving the macula with a large circumferential tear along a vessel. Surgery was performed the same day and the retina was successfully reattached; however, the patient was left with 20/70 corrected visual acuity OS, which was deemed the maximum medical improvement. As a result of his decreased vision, the patient retired from medical practice and sought recovery under two disability insurance policies.

Analysis

The patient sued the OMIC insured over standard of care issues. At question was whether the insured discussed the symptoms of a retinal detachment and if he relayed the importance of immediate treatment if the patient experienced a loss of vision. There were no concerns about the insured's examination of the patient; however, a record keeping issue directly impacted the standard of care. The patient informed the insured, after the fact, that one day before his initial visit he had hit his head on a heavy flower pot while gardening. The patient thought this was most likely responsible for his vision loss, and, under one of his disability policies, a "sudden or accidental" injury would allow him to collect more money.

The insured stated that the patient had drafted a written narrative about striking his head as this would likely benefit him with regard to obtaining the disability monies and had requested that the narrative be placed in his medical record. Unfortunately, the insured then removed his initial documentation and created a second chart note of the visit. This note included the patient's narrative and added that the patient was told to immediately contact the insured if there were any signs of a retinal detachment, such as a sudden loss of vision.

This presented a problem for the defense in that the original chart note did not make any mention of the insured explaining the symptoms of a retinal detachment to the patient, while the second note, which the patient allegedly requested, did. The insured maintained that he did not intentionally fabricate or in any manner embellish the findings of his examination, but had changed the record as an accommodation to his colleague. The plaintiff contended that he did not ask the insured to make any changes to the record and that the insured was covering his tracks and had altered the record in order to boost the defense's position. Defense counsel advised OMIC and the insured that his story about trying to help out a colleague would not be well received by a jury and that alterations or additions to a chart, especially ones perceived as self-serving, usually reflect unfavorably on the defense. The insured agreed to settle.

Risk Management Principles

This case illustrates how physicians can get into trouble when they let personal relationships cloud their professional judgment. It is vital that ophthalmologists treat and keep records on patients they know (friends, family, or office staff) just as they would any other patient. Often, documentation is sparse or nonexistent when a physician has an outside relationship with a patient. In this case, the collegial relationship between the insured and the patient led to a breakdown in record keeping such that vital information about what was said during the initial visit was not recorded in the original documentation. When the insured then attempted to change the record after the follow-up visit, he dealt a death blow to his later defense of this claim.