

Ophthalmic Risk Management Digest

# OMIC DIGEST

## MESSAGE FROM THE CHAIRMAN

## Wrongful Death Claims: Tragic, Complex, and Expensive

By Paul Weber, JD  
OMIC Vice President of Risk Management/Legal

**W**rongful death claims are some of the most tragic, complex, and expensive malpractice litigation that OMIC handles. They are tragic because a grieving spouse or, perhaps, a bereft parent, claims the insured's negligence actually caused the death of their loved one. These lawsuits are legally complex because they usually involve multiple plaintiffs (family members) suing multiple defendants who are alleged to have caused or contributed to the death of the loved one. In wrongful death cases against physicians, the plaintiff must still prove all the elements of a medical negligence case, i.e., duty, breach, causation, and damages. These cases can become very expensive, very quickly, as numerous expert witnesses are retained by both sides to prove or disprove whose negligence, if any, caused the patient's death.

Lending to the complexity of these lawsuits, almost all states have statutes that actually provide for two types of legal actions, often combined in one lawsuit, that may be brought against a physician who allegedly has caused the death of a patient. One action is a claim for wrongful death and the other is a survivor or survival action. The wrongful death action is brought by close family members (e.g., spouse, parent, child) to recover damages for loss of value of the decedent's future earnings/contributions and personal services, loss of the decedent's society and companionship, and pain and suffering arising from the death of the patient. A survival action (somewhat misnamed, since it is only available after someone has died) is pursued by the estate of the deceased patient to recover damages sustained by the decedent prior to death, such as medical expenses, loss of earnings, and pain and suffering. As stated above, the two actions are often combined into what will be referred to in this article as a "wrongful death" claim.

Wrongful death claims are relatively rare against ophthalmologists. They account for only 2.4% of all claims against OMIC insureds and 2.6% of claims against ophthalmologists in the Physician Insurers Association of America Data Sharing Project<sup>1</sup> database. This relatively small percentage is quite notable because over 24% of claims against all specialties combined in the PIAA database involved the death of the

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The year was 1986. Commercial liability insurance carriers were fleeing the market, and ophthalmologists were paying exorbitant premiums for malpractice insurance—if they could buy it at all. Bruce E. Spivey, MD, Executive Vice President of the American Academy of Ophthalmology, was approached

by Academy Board of Trustees Chairman Reginald J. Stambaugh, MD, who advanced the idea that the Academy create its own insurance company for members. A steering committee was formed to determine the viability of this idea. Led by Academy Insurance Committee Chairman John T. Flaxel, MD, the steering committee unanimously supported the idea and convinced the Board to take a calculated financial risk and form an insurance company specifically for ophthalmologists. With \$3 million in surplus contributions collected from nearly 800 Academy member-insureds, OMIC opened for business on October 1, 1987, with Dr. Stambaugh as its first Chairman.

Over the next five years, OMIC tripled its assets and increased investment income fivefold. Dr. Flaxel took over the helm as Chairman in 1994, but it was anything but smooth sailing. The

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# Eye on OMIC

## OMIC

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## OMIC Celebrates 25 Years with Reception and iPad Drawing

October 1, 2012, marked OMIC's 25th year of providing professional liability insurance to members of the American Academy of Ophthalmology. To thank our nearly 4,500 valued policyholders for helping us reach this milestone, OMIC has automatically entered all insured ophthalmologists in a free drawing for a chance to win a new Apple iPad.

The drawing will take place at the OMIC offices on November 7, and the winner will be announced during OMIC's Silver Anniversary Reception at the AAO Annual Meeting in Chicago on Sunday, November 11, at OMIC booth #1104. The winner need not be present to win; however, all OMIC insureds are invited to attend the anniversary reception from 3 to 5 pm. Refreshments will be served.

At the same time, the winner of the iPad will be announced across OMIC's social network. If

you haven't already done so, sign up for OMIC's Facebook, Twitter, or LinkedIn pages to be automatically informed if you are the winner.

OMIC is also offering a separate free drawing for non-OMIC insured American Academy of Ophthalmology members who maintain a primary practice anywhere OMIC offers coverage (currently all states except Wisconsin). Prospects must request a free OMIC professional liability insurance quote between September 1 and November 1, 2012. A single entry will be submitted for each eligible ophthalmologist who is provided a premium quote. No purchase is necessary. The odds of winning are 1 in 4500 for OMIC insureds and 1 in approximately 300 for non-OMIC insureds.

OMIC representatives will be at booth #1104 throughout the meeting to provide rate quotes and answer questions about coverage, discounts, dividends, and ancillary business products.

OMIC also will present or participate in several risk management courses. See the **Calendar of Events** for course times and locations.

## Message from the Chairman

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commercial carriers that had fled the market in the 1980s returned in the 1990s to "buy back" insureds at any cost by offering grossly inadequate premiums in order to drive out physician-owned carriers such as OMIC. In spite of this challenge, OMIC's Board pledged to maintain adequate rates that would be affordable but not necessarily the lowest. OMIC grew steadily to over 2,000 insureds by year 2000 with \$66 million in assets and \$21 million in policyholders' surplus.

In 2001, the predatory, unsustainable business practices of these large carriers resulted in one of the worst malpractice insurance crises in the nation's history. Many carriers doubled or tripled premiums, or simply stopped insuring physicians altogether. The St. Paul Company, the largest physician insurer at the time, withdrew from the market, leaving 40,000 physicians, including hundreds of ophthalmologists, without coverage. Sound fiscal practices had positioned OMIC to withstand the crisis; under the leadership of Chairmen Arthur W. Allen Jr., MD, and Joe R. McFarlane Jr., MD, JD, OMIC added 1,600 new policyholders and doubled assets to \$147 million and surplus to \$43 million over the next five years.

Throughout the last decade, OMIC's average indemnity payment has consistently been lower than multispecialty carriers' average ophthalmic indemnity by nearly 40%. Underwriting Committee and Board Chair Richard L. Abbott, MD, was instrumental in developing risk management and patient safety initiatives for corneal and refractive surgery, oculoplastics, and ROP based on best practices identified from OMIC's own closed claims. This information has given OMIC and its insureds a clear advantage in claims prevention and management.

Today, OMIC is among the strongest of physician-owned carriers with admitted assets of \$232 million, surplus of \$140 million, and an overall A (Excellent) rating from A.M. Best. Our web site, [www.omic.com](http://www.omic.com), is the go-to resource for ophthalmic informed consent documents worldwide. OMIC's confidential risk management hotline responds to over 1,000 calls annually, and attendance at OMIC risk management events has surpassed 30,000 since the program's inception.

OMIC's story is really about our policyholders, from the 800 risk takers who helped fund this start-up company in 1987 to the nearly 4,500 insureds who support OMIC in 2012. It is to you that I extend my heartfelt appreciation for making OMIC what it is today.

**John W. Shore, MD**  
Chairman of the Board



## Ophthalmologists' Liability for the Actions of CRNAs

By Kimberly Wynkoop  
OMIC Legal Counsel

**S**edation or anesthesia for ophthalmic procedures may be administered by anesthesiologists or other qualified anesthesia providers. Ophthalmologists are exposed to legal liability for claims based on the actions of anesthesiologists, and OMIC's policy is available to protect ophthalmologists if they do arise.

### CRNAs as Employees or Agents

Supervising ophthalmologists may be held vicariously liable for the acts or omissions of the CRNA under various theories of liability. The most common is respondeat superior, Latin for "let the superior respond" or "let the master answer." Also termed the "master-servant rule," this doctrine holds an employer or principal liable for the employee's or agent's wrongful (or negligent) acts committed within the scope of the employment or agency.

The fact that ophthalmologists are required to supervise nurse anesthetists' provision of services during a procedure does not, by itself, create an employer-employee relationship, nor does it prevent ophthalmologists from maintaining independent contractor relationships with them (or no formal relationships at all, such as in a hospital setting). The substance of the relationship, not the label, governs the nurse anesthetist's status as an employee or independent contractor. In order to determine whether a CRNA would be considered an employee, there are several factors to consider.

Does the ophthalmologist have a right to direct and control how the nurse anesthetist does the task for which he or she was hired? An employee is generally subject to the employer's instructions about when, where, and how to work.

Does the CRNA bill separately for his or her own services? Independent contractors are more likely than employees to have non-reimbursed expenses and to bill separately for their own services. Whether under contract or not, an employee often will receive benefits and his or her compensation is subject to withholdings.

### Control Over Independent CRNAs

As a general rule, ophthalmologists are not held liable for the negligent acts or omissions of independent CRNAs, even if—for billing and regulatory purposes—they are deemed to be their "supervisors," unless the ophthalmologist controls or directs the actions of the anesthesia provider. Courts generally focus on the amount of control the treating physician exercises over the anesthesia provider to determine whether the physician should be liable for the anesthetist's actions.

To determine if a physician has such control, courts consider who hired, could terminate, and pays the anesthetist, and who has the right to direct the anesthetist in the manner and performance of his or her work. The particular test to determine whether the supervising physician controls the anesthetist's work varies by state.

In ASC and hospital settings, ophthalmologists are often required, under CMS regulations and/or state law, to supervise nurse anesthetists and sign various anesthesia-related orders, evaluations, and reports. It is OMIC's understanding that the role of the treating physician, with relation to the provision of anesthesia services, is to (1) determine whether a patient requires the surgery or diagnostic procedure, (2) request that anesthesia be administered, and (3) determine that the patient is an appropriate candidate for the procedure and anesthesia. Therefore, it is not uncommon for the treating physician to be asked to sign perioperative orders for anesthesia, sedation, and anxiolytic drugs and to co-sign the pre-anesthesia evaluation conducted

by the nurse anesthetist in addition to signing the record of the operation prepared by the circulating nurse as well as the dictated operative report. The fact that ophthalmologists sign certain anesthesia orders, evaluations, or records could be used by a plaintiff's attorney to attempt to prove control, but without further evidence, it would probably not be sufficient.

Even if ophthalmologists do not have general control over a CRNA, the "borrowed servant" theory of liability provides that physicians can be held liable if they "borrow" another's employee and acquire a temporary right of control over the employee that was originally possessed by the lending employer.

### Negligent Supervision and Hiring

The supervising ophthalmologist may also be held liable for the CRNA's actions under the theories of negligent supervision and negligent hiring. Negligent supervision arises from the rationale that physicians conducting professional activities through other professionals such as CRNAs are subject to liability for any injuries caused if the physician is negligent or reckless in supervising such activity. Negligent hiring may be alleged if the ophthalmologist knew or failed to use reasonable care to discover that the CRNA was not competent, fit, licensed, or certified to perform the required duties.

OMIC's professional liability policy covers ophthalmologists for professional services incidents arising from direct patient treatment provided by "any person acting under the supervision, direction, or control of the insured at the time of the professional services incident, so long as that person was acting within the scope of his or her licensure, training, and professional liability insurance coverage, if applicable." In other words, OMIC's policy covers insureds for their liability arising from the supervision of nurse anesthetists, subject to all policy terms, conditions, and exclusions.

# Wrongful Death Claims: Tragic, Complex, Expensive

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patient. The vast majority of death-related claims in the PIAA database arise from pregnancy, malignant neoplasms of the female breast, symptoms involving the abdomen/pelvis, and acute myocardial infarct—conditions that seldom involve ophthalmologists.

There is little difference, however, in the average indemnity payment in wrongful death cases. According to the PIAA data, the average is \$236,000 for ophthalmologists and \$243,000 for all specialties combined. OMIC's average indemnity for a wrongful death claim is somewhat higher than PIAA's at \$295,000 and is nearly twice the \$156,000 average for OMIC's non-death-related claims.

The two most frequent—and expensive—allegations against ophthalmologists in wrongful death lawsuits are improper performance of treatment or procedure and failure to diagnose (see **Frequency and Severity** chart below). This issue's **Closed Claim Study** and **Risk Management Hotline** provide helpful risk management suggestions to minimize liability risk related to improper performance of surgery/procedure and related emergencies that occur in the hospital, ASC, or office procedure area. Wrongful death cases related to diagnostic error are quite different and frequently involve many providers, often over an extended period of time. In diagnostic-related cases, good documentation and communication among providers is often the best risk management practice to minimize adverse outcomes and the best defense if a lawsuit arises.

## Case Study 1—Failure to Diagnose

One OMIC wrongful death lawsuit alleging diagnostic error involved an insured who saw the patient for complaints of swelling OU on January 2, 1995. The differential diagnosis was post-herpetic neuralgia versus sinusitis. The insured ordered a CT scan, which showed probable orbital lymphoma, and consulted with an oncologist and ENT specialist. Upon review of the CT scan, there was a discussion between the oncologist and ENT specialist about whether to get a biopsy. The patient was referred to a radiation oncologist, who began treatment of the left orbit and paranasal sinuses for presumed lymphoma without taking a biopsy. Although the insured testified that he was not involved in the decision to treat the mass or take a biopsy, the records and testimony of the ENT specialist and radiation oncologist indicated they had such conversations with him. The first oncologist had no specific recollection of any conversation with the insured regarding taking a biopsy.

On January 18, one week after radiation treatment started, the patient complained of swelling OU and was treated with prednisone and Tylenol. These symptoms were believed to be due to the radiation treatments. At a visit with the insured one month later on February 15, swelling was down, the eyes were quiet, and visually acuity was 20/20 OS. On February 28, when the patient was seen again by the insured, visual acuity in the left eye had decreased to 20/50 OS. The insured consulted with the oncologist; based on the CT scan, it appeared the lymphoma had

regressed from the radiation. The patient was continued on steroids and warm compresses. On March 16, when the patient was seen again, swelling on the left side had increased, IOP was 38, and visual acuity was 20/80 OS. Again, the insured consulted the oncologist and adjusted the oral steroid dose. Two days later, swelling had decreased and IOP was 12 OS.

On April 1, the patient returned to the insured with reduced vision to light perception only OS. The left pupil was 4 mm and fixed. On April 2, a biopsy was taken using the transthemoidal approach and the patient was diagnosed with a fungal (*Aspergillus*) infection. The insured removed the patient's left eye to help with treatment of the fungal infection. The patient died on May 21. An autopsy was conducted and the cause of death was listed as an *Aspergillus* infection. The fungus infection had caused the hematoma in the left frontal lobe, leading to cerebral edema and uncal herniation. There was no evidence of lymphoma at autopsy. The pathologist estimated the *Aspergillus* had been present in the cranial cavity anywhere from days to weeks.

The plaintiffs in this case were the widow of the patient and two adult children. They brought a wrongful death lawsuit against the insured, the oncologist, the radiation oncologist, and the ENT specialist. The plaintiffs' theory was that the *Aspergillus* infection was present in January or February and should have been diagnosed via biopsy and treated at that time. The plaintiff experts testified that had a correct and timely diagnosis been made, the patient would have survived the *Aspergillus* infection. The plaintiff retained eight expert witnesses. The defendants hired a similar number of experts.

The key expert witness for the insured was a nationally recognized oculoplastics surgeon. He believed the clinical symptoms encountered were consistent with orbital lymphoma, as opposed to a fungal type infection.

## FREQUENCY AND SEVERITY OF OMIC WRONGFUL DEATH CLAIMS

| ALLEGATION                   | NUMBER | NUMBER PAID | TOTAL INDEMNITY |
|------------------------------|--------|-------------|-----------------|
| Diagnostic Failure           | 29     | 8           | \$3,430,000     |
| Surgery—Improper Performance | 24     | 4           | \$1,100,000     |
| Treatment/Procedure—Improper | 19     | 5           | \$988,750       |
| Miscellaneous                | 10     | 2           | \$99,999        |
| TOTAL                        | 82     | 19          | \$5,618,749     |



He felt the patient would have developed a fever in January if a fungus infection had been present at that time. The oral steroid treatment in March caused the periorbital edema to subside, but the steroids would have made the infection worse if it was present as that time. Therefore, it seemed probable to the defense expert that the patient did not develop the fungal infection until sometime in April.

There were some problems facing the insured's defense. The differing recollections regarding the January decision not to do a biopsy and the insured's lack of documentation regarding his exact role in treatment of the lymphoma weakened his case by linking him more closely to the plaintiffs' main liability theory that a biopsy should have been done. Another weak point in the defense was that the insured had the most contact with the plaintiff from January through April. The plaintiff expert argued that the insured continued to treat the patient despite getting poor results rather than refer him to another specialist. The defense thought this was a specious argument as the insured had consulted with the oncologist but believed it might be persuasive to a jury. Moreover, because the case would be tried in a very "plaintiff-friendly" venue, defense counsel put the plaintiffs' chances of prevailing at trial at 50% and estimated that a plaintiff verdict would range from \$1,000,000 to \$2,500,000. Other defense attorneys suggested it could go as high as \$8,000,000.

OMIC had spent over \$180,000 working up the case for trial and had a very experienced defense attorney with an excellent understanding of the clinical issues in the case. However, the consensus of the insured, defense counsel, and OMIC staff was that the clinical issues in this particular case were quite complex, and it was too risky to rely on a jury to understand the roles and duties of the multiple providers. It was felt that they would all be tarred with the same brush.

With the insured's consent, OMIC paid \$250,000 to settle the case. The total combined payment from all defendants was \$1,300,000.

### Case Study 2—Failure to Diagnose

The most frequent type of treatment/procedure arising in a wrongful death claim is the "medical evaluation" and the most frequent type of practice focus is "comprehensive ophthalmologist." One diagnostic error case against a comprehensive ophthalmologist performing a medical evaluation involved a 42-year-old man first seen by the insured in May 1997 for vision problems. He had been examined in November 1996 by another ophthalmologist, who performed a visual field test that was diagnostic for glaucoma. The patient was placed on medication. In May 1997, the patient's primary care physician referred him to the insured, who diagnosed bilateral pterygia. The insured also performed a visual field test in July 1997 but made no notations regarding his impressions or any differences between his fields and those taken by the earlier ophthalmologist, despite having those records available to him. In October 1997, the insured removed the pterygia. Two and a half months after this surgery, the patient returned to his PCP complaining of severe headaches. His PCP felt the headaches were migraine-related, but shortly thereafter, the patient presented to the emergency room with excruciating headache pain. He was discharged without a conclusive diagnosis. The next morning, he was found unconscious and taken to the hospital where he expired the following day. An autopsy revealed that death was due to a pituitary tumor hemorrhage. The widow and three minor children sued the insured, the earlier ophthalmologist, the PCP, two emergency room physicians, and the hospital.

It was difficult to find an expert witness willing to testify on behalf of the insured. The ophthalmologist had

consecutive visual fields that showed an evolving bitemporal hemianopsia. Close review of the formal visual fields show combined arcuate glaucomatous changes and bitemporal hemianopsia. Expert witnesses and consultants in the case described the visual fields as showing "classic" signs of a pituitary tumor. One consultant presented the visual fields to a group of ophthalmology residents. They all diagnosed an intracranial lesion. While the insured testified that he reviewed and compared the visual fields, there was no record or documentation to support this. Nor was there any communication to either the patient or the family physician regarding the test results or contemplated follow-up.

The emergency room physicians and hospital were dismissed from the case based upon a strong causation defense that, by the time the patient came to the emergency room, it would have been too late to operate anyway since surgery or radiation therapy are only effective before the lesion hemorrhages. The family practice physician settled for approximately \$100,000 and the earlier ophthalmologist settled for about \$110,000. With the consent of the insured, OMIC paid \$790,000 to settle the case.

These two case studies involving diagnostic errors highlight the importance of careful documentation and communication with colleagues. Review, date, and sign test results before they are filed in the medical record. Discuss them in letters sent to referring physicians, and provide patients with copies of test results. Follow up on missing results and missed appointments. See [www.omic.com](http://www.omic.com) for recommendations on "Noncompliance" for sample tracking systems and letters to patients.

1. The PIAA Data Sharing Project is the largest independent source of professional liability claims loss data in the world. Since 1985, 267,713 closed claims have been reported to the database, including 7,600 reported claims against ophthalmologists. OMIC does not submit data to the PIAA Data Sharing Project.



# Closed Claim Study

## Co-Defendant CRNA Denies Responsibility for Failed Resuscitation

By Ryan Bucsi, OMIC Senior Litigation Analyst

### ALLEGATION

Negligent resuscitation resulting in death of 45-year-old father of three.

### DISPOSITION

Case settled for \$1,775,000 of which CRNA contributed \$975,000 and OMIC insured contributed \$800,000.

### Case Summary

A non-OMIC-insured ophthalmologist performed cataract surgery on a patient who subsequently developed a hemorrhage OD. The patient was then seen by the insured, who had previously treated his proliferative diabetic retinopathy and bilateral retinal detachments. The insured recommended a vitrectomy under local anesthesia at a surgery center knowing that the patient had tolerated the cataract surgery under local anesthesia. During the vitrectomy, a CRNA administered local anesthesia with IV sedation, and the insured performed a retrobulbar block OD. When the patient became agitated and complained of pain, the CRNA provided more sedation after which the patient turned pale and stopped breathing. The CRNA administered oxygen through an Ambubag but O<sup>2</sup> saturation did not increase. The insured instructed the CRNA to intubate and 911 was called. Despite intubation, the patient's O<sup>2</sup> saturation did not improve. The CRNA confirmed that the tube was in the trachea but asked the surgeon to listen for breath sounds with him; both the surgeon and CRNA heard breath sounds. When the paramedics arrived, they determined that the CO<sup>2</sup> monitor had not changed color indicating the tube was in the esophagus rather than the trachea. This prompted the CRNA to get into a shoving match with one of the paramedics. The paramedic re-intubated the patient and O<sup>2</sup> saturations began to go up. The patient was transferred to the hospital where he died eight days later.

### Analysis

The plaintiff's anesthesiology expert had many criticisms of the insured ophthalmologist. He testified that surgery should not have been performed since the plaintiff had low blood sugar and high blood pressure on the morning of surgery. It was this expert's opinion that, given the patient's medical condition, general anesthesia should have been used, but if local anesthesia was used, the surgery should have been performed in a hospital or facility where an MD anesthesiologist was available.

Since this surgery center did not have an MD anesthesiologist, the expert pointed to the ophthalmologist as the "captain of the ship." The expert testified that the CRNA did not intubate the patient properly and the insured did not diagnose improper esophageal intubation.

The defense expert disagreed with these opinions and the role of a surgeon in anesthesia care. He insisted that the anesthesia provider is responsible for monitoring the patient during surgery. He testified that the CRNA failed to monitor and communicate a low oxygen level to the insured prior to the patient's arrest, thus leading to a delay in resuscitation. Unfortunately, the defense expert was not comfortable rendering an opinion on the standard of care related to the decision to perform surgery. The co-defendant CRNA testified at his deposition that he was responsible for providing anesthesia to the patient, but that the insured was the "captain of the ship." The CRNA admitted that he had not performed an intubation in the five years preceding this case and that he never discussed the risks and complications of anesthesia with the patient because he did not want to scare him. However, he maintained that the intubation was properly done and that the paramedic dislodged the tube. It was defense counsel's opinion that a jury would award the plaintiff \$2.8 to \$4 million and hold the OMIC insured 25% to 50% liable. The CRNA settled first for \$975,000, and the OMIC insured settled later at mediation for \$800,000.

### Risk Management Principles

For the OMIC insured, this could be viewed as a case of being in the wrong place at the wrong time. The procedure was performed in a surgery center with a CRNA who allegedly did not properly intubate the patient leading to a prolonged period without oxygen and eventual death. There are several steps insureds can take to minimize the risk of an improper resuscitation in a surgery center. First, find out if there is a peer review process in place to review the competency of CRNAs and anesthesiologists. Inquire about the emergency response measures in place and whether there is anyone else available within the surgery center to assist with resuscitations. Lastly, call 911 immediately when a potentially life-threatening situation arises.



## Managing Medical Emergencies in the Office

By Anne M. Menke, RN, PhD  
OMIC Risk Manager

Ophthalmologists and staff who work in an ambulatory surgery center or hospital operating room know that patients may have life-threatening cardiac or respiratory problems during a procedure. In these settings, emergency equipment and personnel with advanced training in the management of medical emergencies are on hand. Office-based eye surgeons and staff rarely have to confront such situations and may find themselves unprepared to provide safe patient care in the event of a life-threatening emergency. OMIC has had several cases related to death in the office setting. Lessons learned from these cases may provide assistance to our policyholders.

**Q** We perform fluorescein angiography (FA) in our office. I know that, in rare cases, patients have died from anaphylactic reactions. What should we have on hand when performing FA?

**A** FA is arguably the riskiest office-based procedure in ophthalmology. Based upon a review of expert witness testimony in related claims, it is clear that there is no need for a full “crash cart.” Ophthalmologists do not have the current competency to use most of the drugs and equipment found in crash carts, which are usually located in emergency rooms, intensive care units, and hospital wards. Moreover, few eye surgeons maintain Advanced Cardiac Life Support (ACLS) certification, and so should not attempt intubation or IV administration of emergency drugs. Both plaintiff and defense expert witnesses have opined that an “emergency kit” containing key drugs, such as Benadryl and epinephrine, along with oxygen and equipment to

assist breathing (e.g., Ambubag and age-appropriate airways tubing), were adequate. They also recommended maintaining IV access until after the procedure was completed. There was disagreement about the need for an AED as these are only effective in treating arrhythmias.

**Q** What were the main criticisms?

**A** Rather than focusing on equipment, concerns centered on the lack of preparedness for a medical emergency. In two separate cases, family members were present and later testified that staff seemed harried and confused. They did not know where the oxygen tank and emergency kit were located and lost valuable time. In one case, there was disagreement about protocol and whether to call the anesthesia practice in the building, the code team from the adjacent hospital, or 911. When the anesthesia practice did not respond, they called 911, only to learn that only one of the building’s three elevators was large enough to accommodate a stretcher to the 10th floor, leading to a longer delay in getting emergency treatment. Neither practice kept the drug kit and oxygen in the room where the FAs were performed. And, clearly, neither had conducted emergency drills.

**Q** What is the best way to prepare a protocol for an ophthalmic office?

**A** Evaluate your patient population to determine the most likely and riskiest type of emergency situations, and review the types of procedures performed and anesthesia administered in the office. Offices that administer moderate sedation or perform procedures with a high risk of bleeding need more medications and equipment (see “Office-Based Surgery for Adults” at [www.omic.com](http://www.omic.com)). Take into consideration the skill level of the physician and staff, the distance to the nearest emergency

room, and 911 response time. This evaluation will help determine the materials needed in an “emergency kit.” Offices that do not offer FAs, moderate sedation, or higher risk procedures mainly need to know and recognize the signs and symptoms of medical problems common in adult patients, such as heart and lung conditions that put patients at risk for heart attacks and strokes. All physicians and staff members should have current certification in basic life support (BLS) for health care providers, which will allow them to do CPR if needed while awaiting the ambulance. Diabetic patients may also have hypoglycemic conditions, so a form of glucose should be available. Two persons, including a physician, should be available at all times when patients are in the office.

**Q** What is an emergency protocol?

**A** This is a document that describes the roles of the physician and staff members in the event of an emergency. Here are some common elements. One staff member should stay with the patient while another goes to notify the physician so that the patient’s condition may be evaluated. The physician should quickly determine if 911 needs to be called. The caller should give precise information about the patient’s condition and location and watch for the arrival of the ambulance. The physician should ask one person to document the patient’s condition and the exact sequence of steps taken to treat it (have a form available in the emergency kit). Family members, if present, may be able to assist by providing comfort to the patient. If not present, they should be notified as soon as possible. The protocol should also provide for a staff “debriefing” to collect information and provide support, as well as a plan for staying in contact with the patient and family.



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## Calendar of Events

**OMIC continues its popular** risk management courses this fall and winter. Upon completion of an OMIC online course, CD/DVD, or live seminar, OMIC insureds receive one risk management premium discount per premium year to be applied upon renewal. For most programs, a 5% risk management discount is available; however, insureds who are members of a cooperative venture society (indicated by an asterisk) may earn an *additional discount* by participating in an approved OMIC risk management activity. Courses are listed here and on the OMIC web site, [www.omic.com](http://www.omic.com).

Contact Linda Nakamura at (800) 562-6642, ext. 652, or [lnakamura@omic.com](mailto:lnakamura@omic.com) for questions about OMIC seminars, CD/DVD recordings, or computer-based courses.

### November

**11 OMIC Forum: Top Ten Indemnity Payments in 2011.** Annual Meeting of the American Academy of Ophthalmology. North Hall B, Level 3, McCormick Place, Chicago, IL; 2:00–3:30 pm. Sign in onsite in the presentation room.

**12 Medical Ethics in the Hot Seat: How Compliance with the Academy's Code of Ethics Can Turn a Good Litigation Defense into a Great One.** Annual Meeting of the American Academy of Ophthalmology. Room S105BC, McCormick Place, Chicago, IL; 9:00–10:00 am. Sign in onsite in the presentation room.

**12 Why Take the Risk? How to Create an Effective Risk Management Strategy.** Annual Meeting of the American Academy of Ophthalmology. Room S505AB, McCormick Place, Chicago, IL; 12:45–1:45 pm. Sign in onsite in the presentation room.

### January

**11 Malpractice Claims Studies.** Connecticut Society of Eye Physicians. Aqua Turf Club, Plantsville, CT; time TBA. Register with CSEP at (860) 567-3787.

**20 25 Years of Ophthalmic Claims: One State's Experience.** Hawaiian Eye 2013. Hilton Waikoloa Village, Big Island, Hawaii; 9:30–10:30 am. Register with Hawaiian Eye at <http://osnhawaiianeye.com/> or call (877) 307-5225, ext. 219.

### February

**3 Malpractice Claims Studies.** Ohio Ophthalmological Society. Hilton Columbus at Easton Town Center, Columbus, OH; time TBA. Register with OOS at (614) 527-6799.

### March

**8 Malpractice Claims Studies.** Illinois Association of Ophthalmology. Donald Stephens Convention Center, Rosemont, IL; time TBA. Register with the IAO at (847) 680-1666.