Ophthalmic Surgery Malpractice Claims

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No Financial Disclosures

Meet the presenter

Melanie Rubinsky, JD, LL.M.

Melanie has been a shareholder with Sprott, Newsom, Quattlebaum & Messenger since 2019, focused on representing those in the healthcare industry. She has worked in the legal industry for over 37 years and has extensive experience representing healthcare institutions and medical professionals in matters involving medical negligence, peer review, licensure, risk management, business disputes, contractual issues, regulatory compliance, fraud, and more. Melanie is a member of the State Bar of Texas Health Law and Litigation Sections and serves on the Education Committee for the Greater Houston Society for Healthcare Risk Management.

Introduction

Malpractice claims are an unfortunate reality in the medical field, and ophthalmology is no exception. Today, we will delve into the specific realm of malpractice related to anesthesia and surgery in ophthalmology, examining its causes, implications, and potential preventive measures. By understanding these challenges, we can strive to enhance patient safety and provide the best possible care.

Importance of Ophthalmic Surgery

Ophthalmic surgery plays a vital role in improving patients' vision and quality of life. However, due to the delicate nature of the eye and its surrounding structures, surgical interventions in ophthalmology present unique challenges. Anesthesia management during these procedures is crucial to ensure patient comfort, safety, and optimal outcomes.

Common Causes of Ophthalmic Anesthesia Malpractice

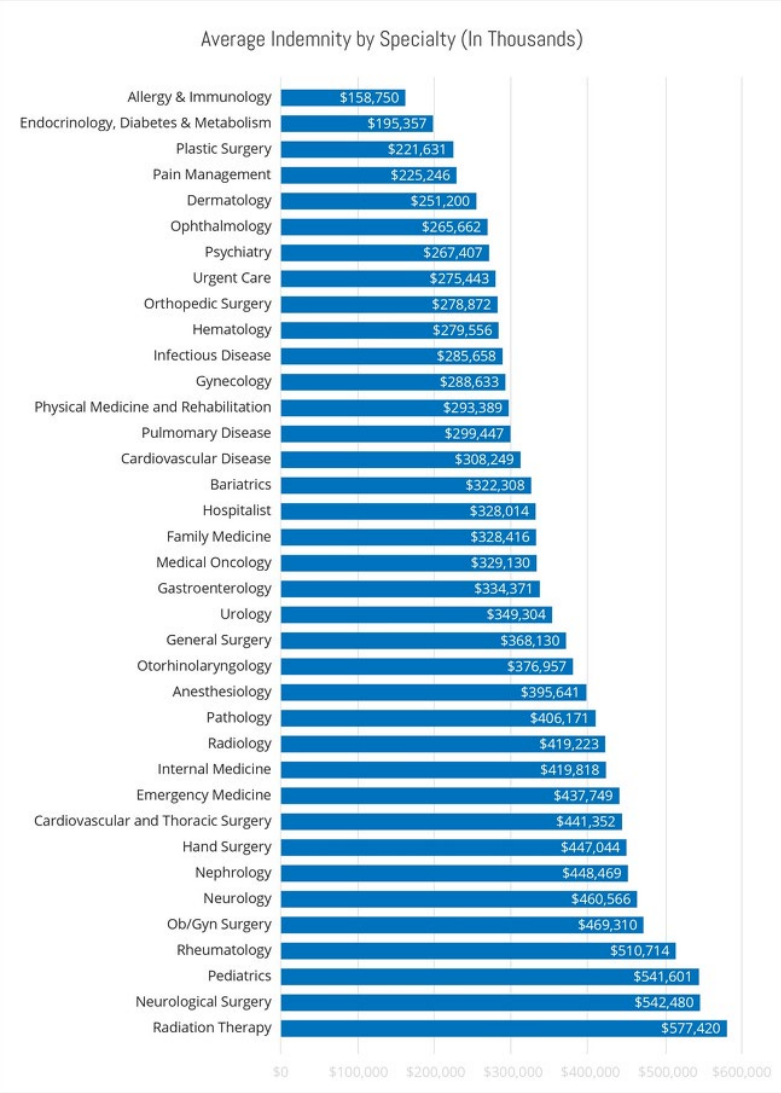
- Inadequate preoperative assessment
- Medication errors
- Anesthesia-related complications
- Surgical errors
- Informed consent issues
- Post-procedural infection
- Failure to follow up with patients

Impact and Risk of Malpractice in Anesthesiology

Malpractice claims related to anesthesia and surgery in ophthalmology can have significant repercussions:

- Patient harm and compromised outcomes
- Harm to professional reputation
- Legal implications, including licensure risk
- Financial implications

Impact and Risk of Malpractice in Anesthesiology



*data from TMLT Quarter 4 2023 report

<u>Top presenting medical conditions – reasons for patient visit, reason patient seeking treatment in the first instance</u>

- Dorsalgia
- Pain
- Thoracic, thoracolumbar, and lumbrosacral intervertebral disc disorders
- Other spondylopathies
- Osteoarthritis of the knee

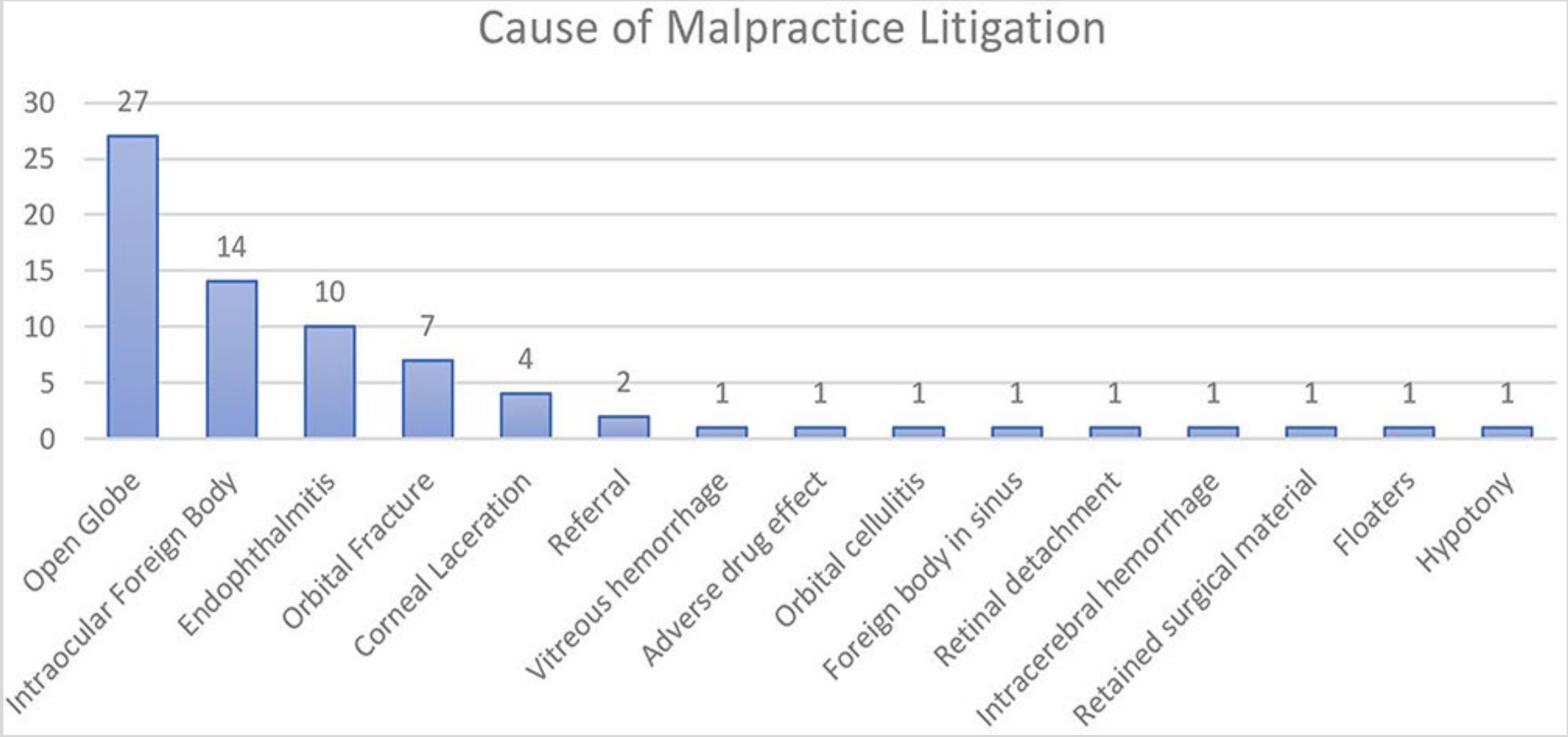
<u>Top outcomes – medical condition that occurs after encounter with medical provider, leading to claims</u>

- Cardiac arrest
- Intraoperative and postprocedural complications and disorders of nervous system
- Accidental puncture or laceration during procedure
- Other disorders of brain

<u>Top chief medical factors – reasons for claims against medical providers</u>

- Procedure: Incomplete or inadequate
- Procedure: Failure to recognize complications
- Medication/IV Fluids: Adverse drug reactions

Malpractice Litigation in Ophthalmic Trauma (July 2020)



Ocular Anesthesia Claims: Causes and Outcomes

OMIC – Review of Claims (2008 – 2018)

- Study looked at 63 anesthesia-related claims or suits filed by 50 plaintiffs.

- Anesthesia-related injuries included:
    - Globe perforation (17)
    - Death (13)
    - Retrobulbar hemorrhage (7)
    - Optic nerve damage (4)
    - Vascular occlusions (2)
    - Pain (2)
    - Eye or head movement resulting in injury (2)
    - Numbness, diplopia, and tooth loss during intubation (1)

- Types of Anesthesia
    - Retrobulbar and peribulbar anesthesia (16)
    - Local infiltration around lids and facial nerve (6)
    - Topical anesthesia (5)
        - Inadequate pain control (2)
        - Ocular movement resulting in capsular rupture (2)
        - Death (1)
    - General anesthesia (5)
        - Death (4)
        - Loss of tooth during intubation (1)

- Indemnity Payments/Claim Disposition
    - Indemnity Payment to Plaintiff (16 or 25%)
    - No Payment – Suit Successfully Defended or Dismissed (75%)
    - Perforations most common and most expensive injury – 6 claims averaging $271,000
    - Death was second most common outcome resulting in payment – 5 claims averaging $73,500
    - Retrobulbar hemorrhage – 4 claims averaging $92,500
    - Indemnity payments averaged $158,678 (median $75,000; range $15,000 - $585,000)

Malpractice Risk by Physician Specialty

- 2011 Rand Study
  - Across specialties, 7.4% of physicians annually had a claim, and 1.6% made an indemnity payment.
    - Neurosurgery – 19.1% annually faced a claim
    - Psychiatry – 2.6% annually faced a claim
  - The proportion of indemnity payments was not in direct correlation to the specialties with higher proportions of claims.
  - Most physicians can expect to face at least 1 malpractice claim over a 30-year career.
    - By age 45, 36% of physicians in low-risk specialties are likely to have had at least 1 malpractice claim, compared to 88% of those in high-risk categories
    - By this same age (45), 5% in low-risk specialties and 33% in high-risk specialties are likely to have made at least 1 indemnity payment
    - By age 65, 75% of physicians in low-risk specialties and 99% of physicians in high-risk specialties are likely to have had at least 1 malpractice claim, and 19% of those in low-risk specialties and 71% in high-risk specialties are likely to have had at least 1 indemnity payment.

- 2023 AMA Study
  - 1/3 of US physicians in 2022 reported having previously been sued.
    - However, when claims proceeded to trial and a verdict was rendered, 9 out of 10 were defense verdicts.
  - It is virtually a matter of time before a physician is sued and the longer the physician is in practice, the higher the exposure of risk for a medical malpractice lawsuit.

Malpractice Risk by Physician Specialty

- 2023 AMA Study
  - Nearly half of physicians over the age of 54 had been sued as compared to 9.5% of physicians under the age of 40.
  - On average, physicians over the age of 54 had a 1 to 1 claim rate (100 per 100 physicians).
  - Physicians under the age of 40, however, had 11 claims per 100 physicians.
  - The highest variation in claim frequency was attributed to the medical specialty that defines the physician's clinical focus.
    - Surgical specialists have a higher risk of claims and internal medicine specialists have a lower risk of claims.
    - OB/GYNs, general surgeons, and orthopedic surgeons have the highest risk, with 62% of OB/GYNs and 59% of general surgeons as opposed to 7% of allergists/immunologists and 8% of hematologists/oncologists.
  - Before age 55, 43.9% of general surgeons and 47.2% of OB/GYNs had already been sued at least once.
  - Female physicians have a lower risk of being sued than male physicians – 23.8% v. 36.8%.
  - Anesthesiologists fall around the middle of the pack of medical specialists, while ophthalmologists fall at a slightly lower percentage than anesthesiologists, both on claims made and claims with indemnity payments.

Texas Civil Practice & Remedies Code Chapter 74
Texas Medical Liability Act

A "Health Care Liability Claim" is defined as:

A cause of action against a health care provider or physician for treatment, lack of treatment, or other claimed departure from accepted standards of medical care, or health care, or safety or professional or administrative services directly related to health care, which proximately results in injury to or death of a claimant, whether the claimant's claim or cause of action sounds in tort or contract.

Tex. Civ. Prac. & Rem. Code §74.001(13).

Texas Civil Practice & Remedies Code Chapter 74
Texas Medical Liability Act

In order for a Plaintiff to successfully bring suit against a healthcare provider, the Plaintiff must be able to prove, by a preponderance of the evidence, the elements of the statute:

- Duty
- Breach
    - Standard of Care – reasonably prudent physician under the same or similar circumstances
- Causation
    - Causal connection between the breach of the alleged damages
- Damages

Texas Civil Practice & Remedies Code Chapter 74
Texas Medical Liability Act

The statute imposes requirements of a Plaintiff in order to pursue a medical malpractice case in Texas:

- Pre-suit notice of claim, along with statutorily compliant authorization for release of PHI (§§74.051 and 74.052)
- Statue of Limitations (§74.301)
- Expert Report Requirements (§74.351)
- Expert Witnesses (§§74.401 - 74.403)

In addition, the statute addresses:

- Informed Consent (§§74.101 – 74.107)
- Emergency Care (§§74.151 – 74.155)
- Caps on Non-Economic Damages (§§74.301- 74.303)

Rules and Regulations

- Texas Occupations Code (Chapters 151-171)
  - Medical Practice Act
  - Includes the enabling statutes and practice acts for physicians

- Texas Administrative Code (22 Tex. Admin. Code, Chapters 161-185, 187, 189-200)
  - The purpose of the Texas Medical Board is to protect the public's safety and welfare through the regulation of the practice of medicine. (§161.2(a))

Stark and Anti-Kickback Laws

- Ophthalmology practice pays $2.9 million to settle kickback allegations (March 2023)
    - Texas ophthalmology provider group settled its Stark/Anti-Kickback Civil suit brought by the US Attorney's Office for almost $3 million based on allegations it offered and paid kickbacks to optometrists to induce patient referrals who were candidates for cataract surgery.
    - The US Attorney's office: "Paying kickbacks to providers incentivizes doctors to treat patients based on illegitimate financial gain, rather than the patient's need and best interest."
    - The US Attorney's office has set up a specific task force in Texas to investigate and prosecute physicians under these Federal and State statutes.

Case studies: Baty v. Futrell, 543 S.W.3d 680 (2018)

What happened?

- Barbara Baty underwent cataract surgery. The attending CRNA administered anesthesia for the procedure by means of a retrobulbar block. Baty alleged that the CRNA inserted the needle into her left optic nerve, causing permanent nerve damage and vision loss in that eye.

What issues?

- Standard of care?
- Breach?
- Causation?

Case studies: Bustamante v. Ponte, 529 S.W.3d 447 (2017)

What happened?

- Baby Bustamante was born prematurely and had a risk of developing retinopathy of prematurity (ROP). Baby's ophthalmologist recommended a 4-week follow-up instead of 1-week and failed to perform a proper laser treatment, resulting in Baby suffering permanent vision loss.

What issues?

- Standard of care?
- Expert testimony as a means of proving causation of injuries?

Case studies: Gunderson v. Wade, No. 14-20-00795-CV, Tex. App. – Houston[14th Dist.] Feb. 15, 2022

What happened?

- Pediatrician referred Plaintiff to Defendant ophthalmologist because Plaintiff's left eye looked outward. Defendant performed strabismus surgery on both eyes. Eight months later, Plaintiff presented to pediatrician twice due to headaches and vomiting and was taken to the ER where a CT scan showed a left occipital tumor in his brain, which was surgically removed. Pathology testing showed it was a ganglioglioma, a slow-growing tumor, which would have been present when Defendant examined and operated on the Plaintiff. Plaintiff lost ¼ vision in each eye.
- Plaintiff's expert was an ophthalmologist. Defendant moved to dismiss the case on the grounds the expert opinion on causation was "speculative and conclusory."

What issues?

- Qualifications of expert witnesses?
- Expert testimony as a means of proving causation of injuries?

Case studies: Edwards v. Sunrise Ophthalmology Asc, LLC, 134 So.3d 1056 (2013)

What happened?

- Plaintiff had a lower eyelid surgery and contracted a rare bacterial infection following the procedure, requiring her to undergo additional surgeries and to sustain disfigurement in that eye. She sued the surgeon and his practice for malpractice and relied on the testimony of an infectious disease doctor at trial. Judge ruled that the infectious disease doctor was not sufficiently qualified as a specialist to offer expert medical testimony related to ophthalmic surgery.

What issues?

- Qualification of experts?
- Areas of specialty?

Malpractice Case Study: CRNA – Improper Technique

What happened?

- 79 year old male was scheduled to have cataract surgery on the right eye. The CRNA was called in to perform a peribulbar eye block on the patient prior to his cataract surgery. The CRNA performed two needle sticks in different locations around the eye to administer the numbing medication. Shortly after the injections, the CRNA reapplied the Honan-Balloon she had removed to perform the eye block.
- When the patient arrived at the operating room, the Honan balloon pressure was at 20mm mercury. However, the eye surgeon noted that there was the presence of either a potential vitreous hemorrhage, a retinal detachment, or a choroidal effusion or hemorrhage. The decision was made to abort the cataract surgery and immediately refer the patient to a retina specialist.
- Patient was seen by a retina specialist who diagnosed him as having choroidal hemorrhages. Over time, the patient underwent multiple procedures in an attempt to repair the hemorrhage but eventually lost complete vision to his eye.
- Notably, during treatment of his choroidal hemorrhages, no healthcare provider ever identified a perforation or tear in the globe of the patient's eye
- Allegations
- CRNA "went too deep" and got "behind the eye" and perforated/tore the globe of the eye during one of the two injections, resulting in permanent blindness to the patient's right eye.
- Outcome

Malpractice Case Study: Perforation of the Globe of Eye

What happened?

- Female patient undergoing routine cataract surgery by eye surgeon. Anesthesiologist performed anesthesia in the form of a peribulbar block.
- The following day, after an uneventful cataract procedure, the patient was unable to see out of the eye and went for testing that revealed the anesthesia needle inserted by the anesthesiologist had actually perforated the globe of the eye, with possible administration of the anesthesia into the eye, resulting in blindness.
- Patient is now permanently blind in the eye

Allegations

- Sued both anesthesiologist and ophthalmologist, alleging the defendant surgeon had not adequately vetted the anesthesiologist to perform the nerve-blocking procedure.
- Ultimately settled for $1,150.00 – 2018 Massachusetts.

Malpractice Case Study: Failure to Evaluate Patient

What happened?

- 72-year-old man was evaluated by Ophthalmologist A on several occasions. Patient had cataracts, with best corrected visual acuity of 20/25 in the right eye and 20/40 in the left. Ophthalmologist A recommended surgery to remove the cataract from the left eye. Patient underwent uncomplicated cataract surgery with intraocular lens implant on patient's left eye. Patient was prescribed both pre- and post-operative antibiotics and steroidal eye drops. Ophthalmologist A saw the patient the next day for a post-operative examination. Patient reported a slight headache and that his vision was still "a little cloudy." Ophthalmologist A noted 2+ inflammation in the left eye but did not find it to be concerning.
- Two days after surgery, patient called and spoke with Ophthalmologist B, who was taking calls for Ophthalmologist A. Patient claimed he reported floaters, decreased vision, and the sensation of looking through a lace overlay in the left eye. Ophthalmologist B recalled that patient did not complain of any pain, which would be expected if there was an infection. Ophthalmologist B also claimed that he offered to see the patient in the office that day (a Saturday) and told him to call back if his condition changed. Ophthalmologist b did not document this conversation in the patient's medical record.
- Patient recalled the conversation differently.

What issues?

- Lack of Documentation?
- Outcome ?

Malpractice Case Study: Vision Loss Following Surgery

What happened?

- 41 year old female was referred to an orthopedic surgeon with a history of progressive lumbar scoliosis secondary to spasticity from congenital diastematomyelia. The surgeon planned a two-stage surgical correction of the scoliosis.
- The first operative stage was uneventful and consisted of an anterior lumbar interbody fusion with instrumentation at L4-5 and L5-S1.
- The second stage of the surgery – a posterior fusion and instrumentation from T8-S1 was planned for the next day. Lab work obtained before the second surgery indicated the patient's hematocrit was 27.5%. To control intraoperative hemorrhage, the orthopedic surgeon requested hypotensive anesthesia.
- Day after second stage, the patient developed facial edema and complained of blurred vision, greater in the left eye. An ophthalmologist diagnosed intraoperative ischemic optic neuropathy, most likely caused by a relative lack of perfusion to the optic nerve.
- Although the patient's vision improved, she was discharged 8 days after the surgery. Her vision was 20/40 in the right eye and 20/400 in the left. She continued to see an ophthalmologist with a final outcome of tunnel-type vision with holes in her vision. She was classified as legally blind in the left eye and Social Security determined she was totally disabled.

Allegations

- Death of retinal cells caused by a lack of oxygen during surgery.
- Lack of oxygen brought about by the hypotensive condition during the prolonged surgery, the anemic condition before and during surgery, and the pressure of a prolonged surgery (7.5 hours) in the prone position.

Most Common Legal Defenses in Medical Malpractice Cases

- Not Below the Standard of Care/Not a Deviation
- No Causation
- No Damages
- Natural Consequences
- Assumed Risk of the Procedure/Patient Gave Informed Consent
- No Guarantees
- Pre-Existing Conditions/Co-Morbidities
- Non-Compliant Patient
- Another Provider's Fault (Finger Pointing)
- Statute of Limitations

What preventive measures can we take to mitigate the risk of malpractice claims?

To mitigate the risk of malpractice related to anesthesia and surgery in ophthalmology, we can implement several preventive measures:

- Enhanced preoperative evaluation – Conduct thorough preoperative assessments, including comprehensive medical history, allergy screening, and medication review.
- Robust team communication – Foster effective communication and teamwork among the surgical team, anesthesiologists, and nurses to ensure a shared understanding of the patient's needs, risks, and potential complications.
- Adherence to evidence-based practices – Stay updated with the latest guidelines and best practices in ophthalmic anesthesia and surgery to ensure the delivery of optimal care.
- Informed consent – Clearly communicate the risks, benefits, and potential complications of the surgical procedure and anesthesia to the patient, ensuring they fully understand and provide informed consent.

Avoiding Medical Malpractice Claims and Being Reported to the Medical Board

- Lastly, and certainly not the least important, is to document, document, document!!
- What may seem benign or insignificant to you, could be the difference between a dismissal and a monetary verdict, or the imposition of a disciplinary order by the Medical Board and a dismissal of a patient complaint.
- Many malpractice claims come down to a lack of documentation in the patient's chart.
- Plaintiffs and their attorneys will take the position, and argue to the jury, that if it isn't written down in the patient's chart, it wasn't done.
- The Medical Board will take the same position – if you didn't write it down, you didn't do it.
- EMR systems have helped; however, it is imperative that a physician be as thorough and specific as possible in documenting a patient's chart – from the informed consent process through the post-surgical care.

Thank you

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