An Ophthalmolgist's view of Medicolegal cases

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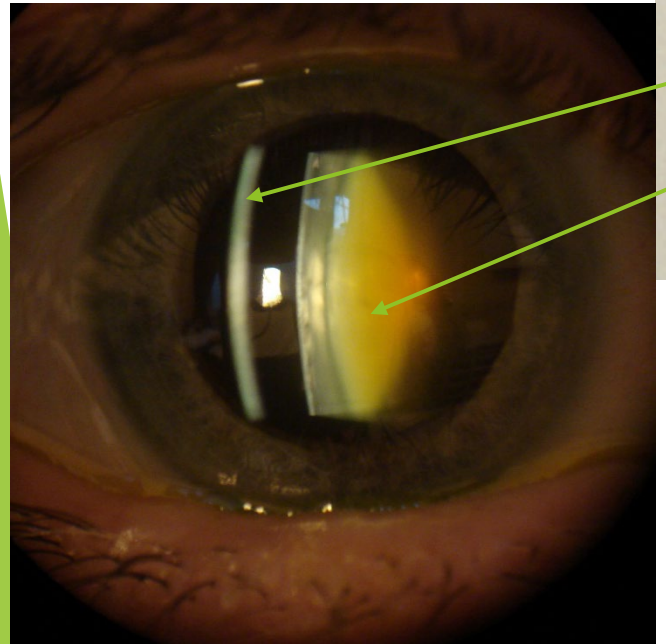
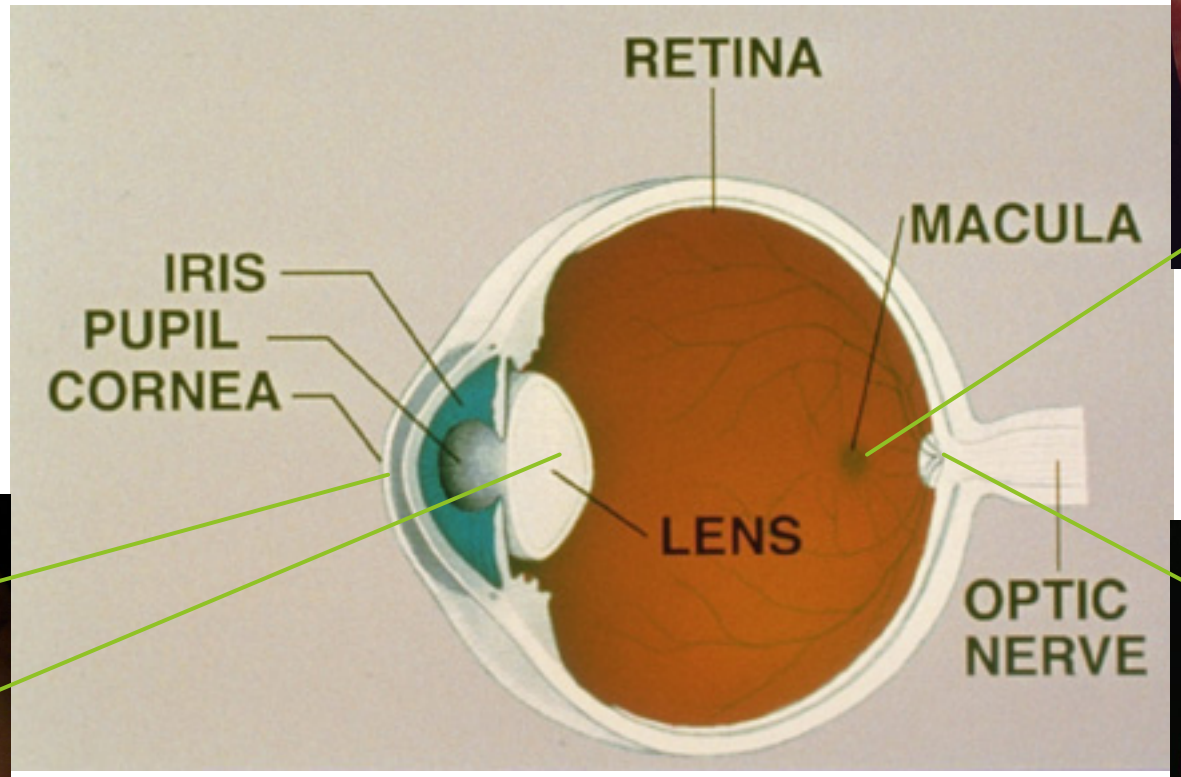
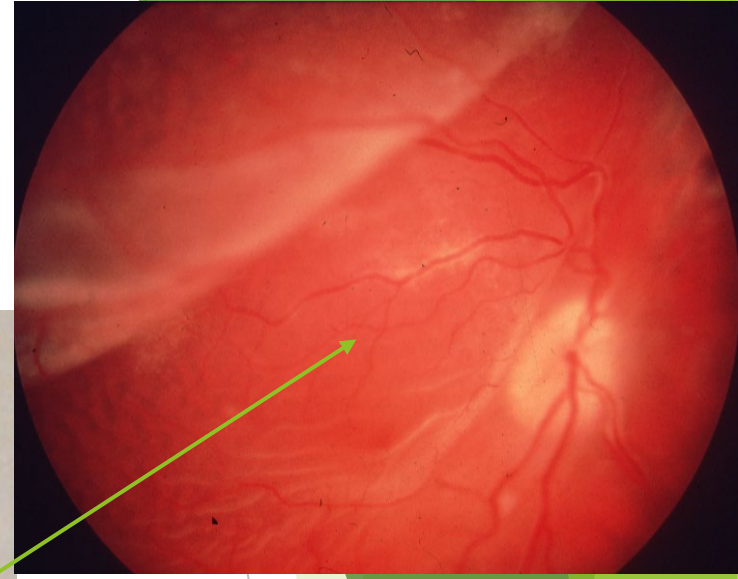
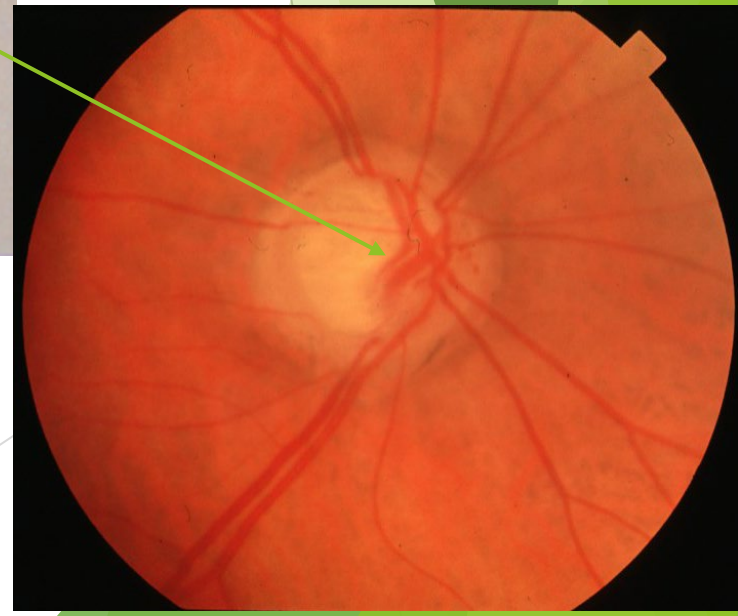
Overview of the eye



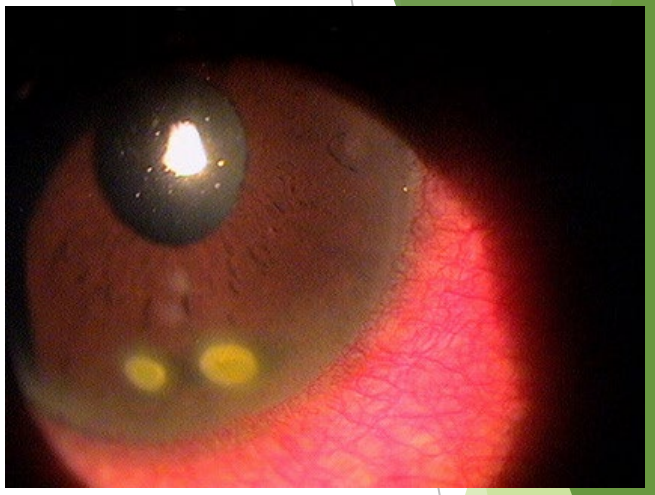


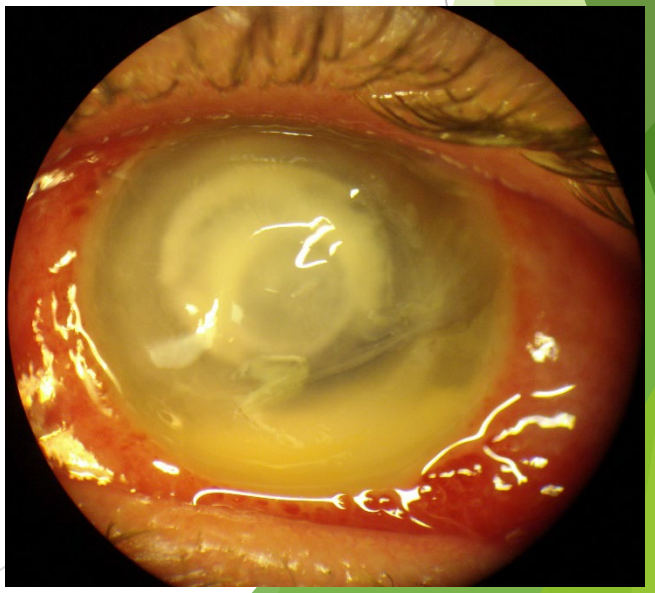




Case 1 Delayed referral of corneal infection

- Claimant presents to his regular optometrist as an urgent extra, Thursday afternoon, with uncomfortable eye
  - Soft contact lens wearer
  - Diabetic
- Inflammation on cornea noted
- Optometrist thinks it is sterile hypoxic (CLPU), asks colleague to see it
  - Leave out contact lens
  - Chloramphenicol antibiotic eye drops
  - Review Monday morning (no appointments available on Saturday)
  - Patient advised to return sooner or go to A&E if his eye gets worse, more painful, reduced vision
- Patient gets much worse over weekend and on Monday has an obvious and severe corneal ulcer
- Prolonged medical treatment required but eventual clearance of infection and VA of 6/18





Allegation

- That optometrist should have identified the inflammation as infection not sterile CLPU and referred immediately to A&E
- That the alleged delay in referral led to a worse outcome for the patient with loss of vision

Questions on both liability and causation

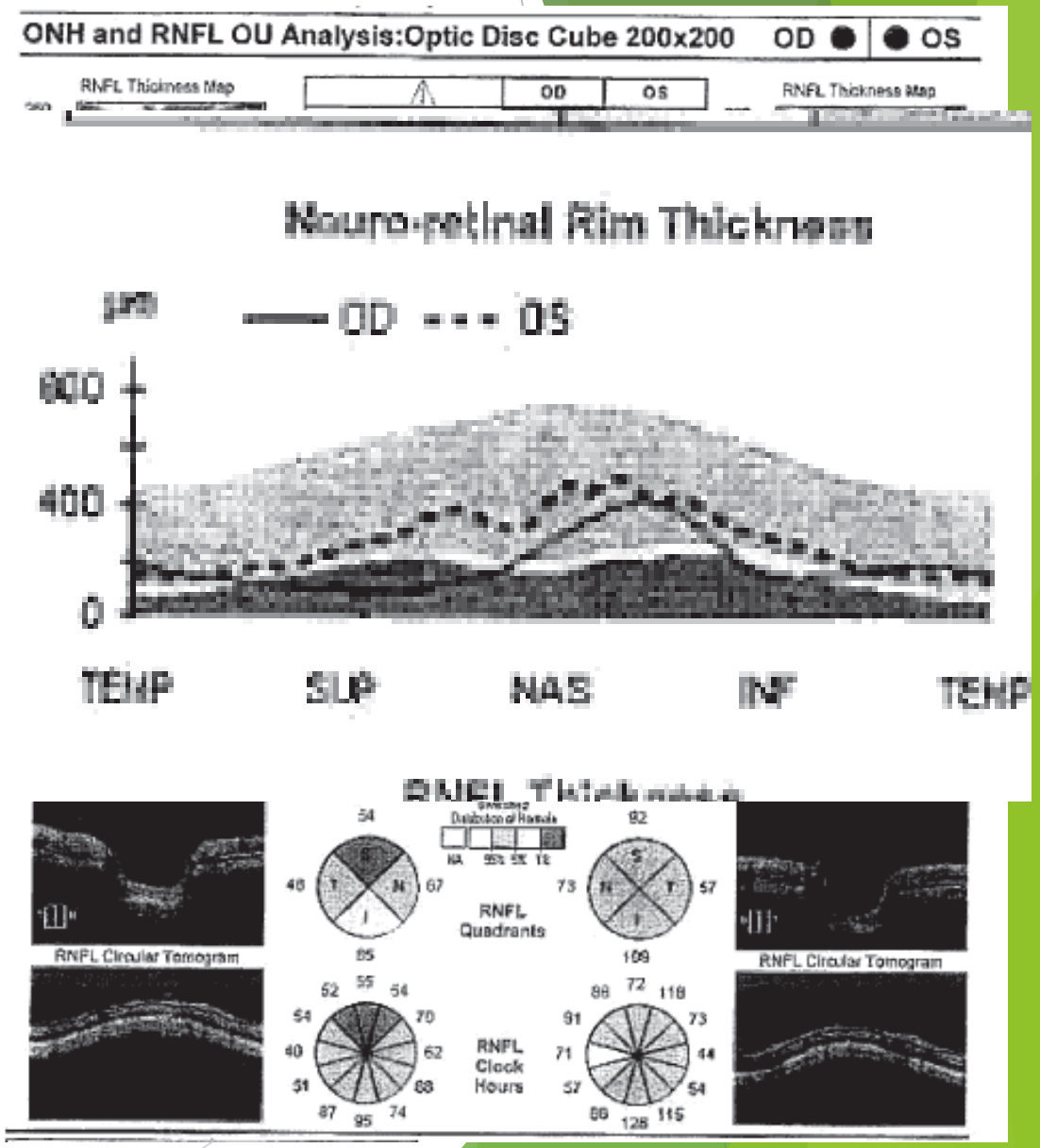
- Was the standard of care by the optometrist adequate?
  - Very thorough examination by experienced optometrist – it looked like CLPU
    - circular
  - Reference to optometry guidelines – treatment was correct for CLPU
    - But CLPU was the incorrect diagnosis
  - Contemporaneous local A&E referral guidelines discourage referral
- Was the outcome worse but for the alleged delay?
  - Range of outcomes from pseudomonas infection
    - Vision loss at least partly due to initial infection
    - Delayed diagnosis more likely to result in a poor outcome
    - The outcome in this case is ~ median for Pseudomonas, would have been better still if diagnosed and treated earlier?
  - Contributory negligence by patient

Issues

- An ophthalmologist is not the best person to judge the standard of care by an optometrist
- A severe condition such as bacterial corneal infection may result in a poor outcome even with prompt and correct treatment
- Patient initiated follow-up and safety-netting are increasingly used in medical care. Who is responsible if the patient does not follow advice?

Case 2. Delayed diagnosis of glaucoma

- Optometrist carried out the correct test (OCT) but misinterpreted it
  - Better quality copying please…
- Other tests such as visual field not carried out
- Patient seen by another optometrist 2 years later and referred to hospital



Liability clear, causation difficult

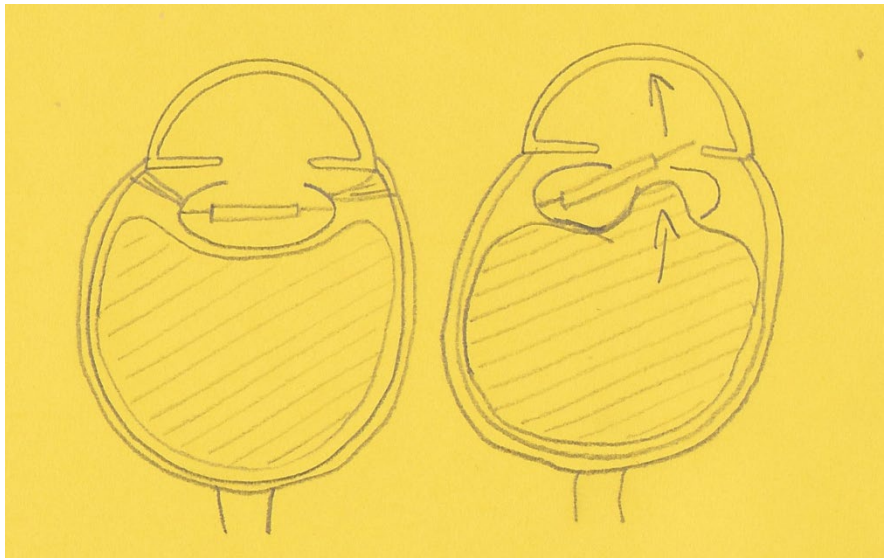
- Glaucoma is a progressive and irreversible disorder and it is reasonable to assume that after 2 years without treatment the condition will have worsened
  - Patient now has symptoms of deteriorating vision
  - But, repeat OCT examination does not show change
  - No previous visual fields to compare
- Glaucoma tends to progress even with treatment, but more slowly. There is no study that compares treatment with no treatment
  - Because the optometrist did not measure visual field there is limited data to use to assess progression
  - Cannot demonstrate a different outcome ‘but for’ the alleged breach of duty

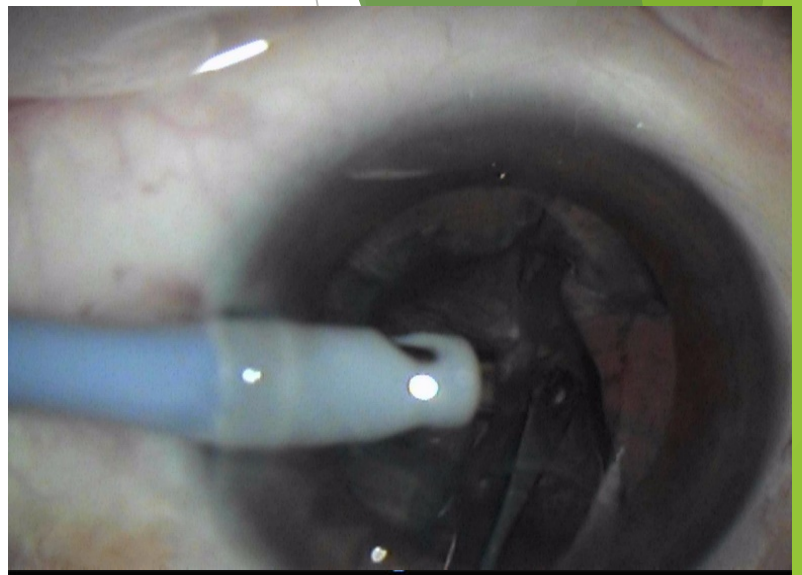
Issues

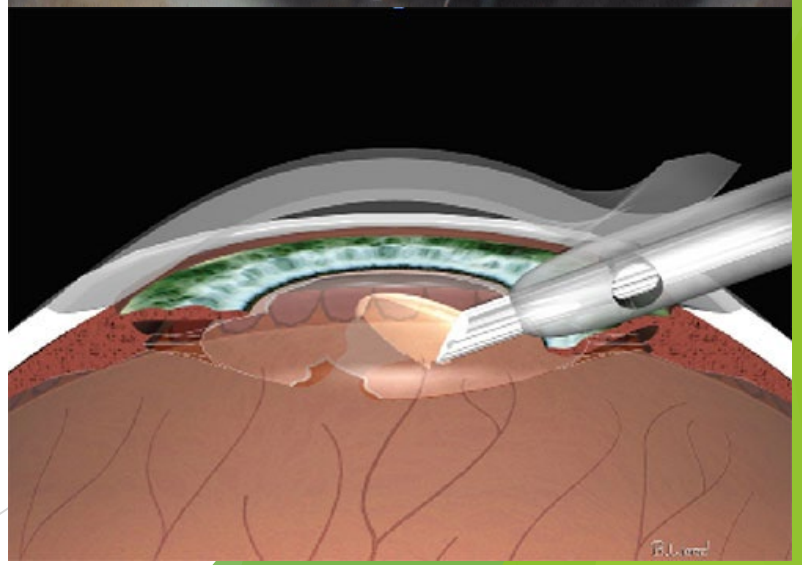
- Poor documentation may make it difficult to assess quality of care or change in condition
  - Poor copies of scans and photos delay opinion
- Difficult to answer the ‘but for’ question in a progressive condition with imperfect treatment (glaucoma, macular degeneration, diabetic macular oedema)
- Similar issues are likely to arise with loss-to-follow-up and delay in appointments due to COVID

Case 3. Cataract surgery complication

- NHS surgery at private hospital
  - Information leaflets etc. not recorded
  - Consent taken on the day
- PC rupture not documented by surgeon
- Limited surgical record but unusual surgical steps suggest that the surgeon knew there was a problem but did not deal with it correctly







Liability

- PCR is a recognised complication (1-2%) of cases
  - not of itself a sign of below standard care
  - No requirement of surgeons or hospitals to publish their figures
- No actions to identify complications and the steps that were taken resulted in predictable outcome of very high pressure post-op
  - Impression of ‘denial’
  - This was sub-standard care

Causation

- But for the substandard management of PCR the claimant would not have suffered severe pain in 24 hours post-op due to incorrect surgery and would not have needed to attend the second hospital for several appointments and an additional operation
- But, the eventual outcome was good vision
  - PCR increases risk of subsequent complications (e.g. retinal detachment) but these did not arise
  - Had a complication arisen it would have been due to the PCR rather than the substandard treatment of the PCR

Issues

- Causing e.g. PCR is not substandard care, but what if a surgeon's PCR rate is high but not published?
- Distinguishing between the effect of a complication such as PCR on the outcome and the effect of poor management of the complication