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Giant Cell Arteritis: Delayed diagnosis and treatment

JANE MOCK, CPHRM, OMIC Risk Manager and RON W. PELTON, MD, PhD, OMIC Director

Allegations of failure to diagnose are common in medical malpractice lawsuits against ophthalmologists, and diagnostic error is an issue of ongoing concern in the healthcare community. In fact, one of the "Top 10 Patient Safety Concerns" listed in an ECRI (formerly the Emergency Care Research Institute) and Institute for Safe Medication Practices (ISMP) 2022 special report is "Cognitive Biases and Diagnostic Error."[1]

Some ophthalmic conditions, such as giant cell arteritis (GCA), have a short window for diagnosis and treatment. Giant cell arteritis is a relatively rare condition, mostly affecting patients over the age of 50. Ophthalmologists are familiar with the classic signs of GCA – vision changes, headache, jaw pain, fever, and scalp tenderness – yet, if they don't appreciate the significance of those signs and symptoms or recognize that GCA often does not exhibit "classic" signs and symptoms, they may not follow through to confirm the diagnosis and coordinate treatment. The patient then risks severe bilateral vision loss, and the treating ophthalmologist incurs liability exposure.

INDEMNITY PAYMENTS MADE TO SETTLE GCA CLAIMS (2016–2021)

	GCA Claims	All OMIC Claims
Closed with payment	9	1,420
Average indemnity paid (mean)	$450,000	$265,929
Median indemnity paid	$500,000	$97,500
Highest payment	$750,000	$2,000,000

Over the years 2016 through 2021, OMIC closed 13 claims involving failure to diagnose or delayed diagnosis of GCA. Of those 13, nine (69%) were settled, totaling just over $4 million in indemnity payments. As the table shows, the number of GCA claims settled represents a small portion of all OMIC claims settled; however, the amount of indemnity paid for these claims is significant.

The high-stakes consequences of GCA, for both patient and provider, call for strengthening the diagnostic and patient management process. This article explores aspects of the diagnostic process and offers risk management recommendations to help ophthalmologists reach better outcomes relative to GCA.

History, exam, and work-up

A literature review by Muro-Fuentes and Stunkel (2022) observes that failures to obtain an adequate history, complete exam, and appropriate imaging, as well as failures to develop a differential diagnosis, are often at the root of neuro-ophthalmic diagnostic errors. The authors recognize that the complicated nature of neuro-ophthalmic conditions and the need for detailed exams create a risk of misdiagnosis. Their study focuses on diagnostic ***process*** error (i.e., the failure to obtain imagining in a timely fashion, as opposed to failing to "assign the correct diagnostic label"

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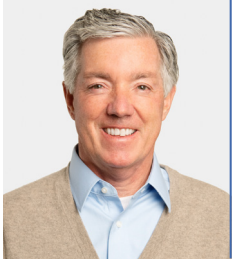
MESSAGE FROM THE CHAIR



DANIEL BRICELAND, MD, OMIC Board of Directors

I have spent my entire career in the trenches advocating for our patients and profession. As ophthalmologists, we've been engaged in a valiant fight to defend the facts we all know to be true – ophthalmic surgical practice requires the training and education achieved during our years of medical school, residency, fellowship, and hands-on experience.

Yet, we now feel pressures to delegate complex procedures, including surgery, to ancillary providers. This should concern us all. There are no short-cuts when it comes to our patients' vision. Any changes in our protocols for ophthalmic care should be approached with the utmost caution.

Thankfully, most ophthalmic procedures proceed with good outcomes. But not all of them. In my role as OMIC Claims Committee Chair, I saw cases that went south. As ophthalmologists, we face unexpected complications even when performing procedures some mischaracterize as "lower risk" to patients. I've seen the devastation that sets in when colleagues realize that, despite their best efforts, they could not avoid the inevitable, albeit rare, poor result. We will all face this reality during our careers.

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EYE ON OMIC

Board changes and a new Chair announced for 2023

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OMIC will be without the incredible talents of several Board and Committee members whose terms expire at the close of 2022.

Dr. Denise Chamblee distinguished herself as one of the most influential Board members in recent memory, serving on the Executive Committee and chairing the Risk Management and Nominating Committees.

Dr. Bradley Fouraker similarly impacted OMIC as one of the most active voices on OMIC's Board for more than fifteen years. His advocacy in both his home state of Florida and nationally has won him accolades among his peers at both OMIC and the American Academy of Ophthalmology.

Dr. Pauline Merrill has contributed extensively and fiercely defended the interests of ophthalmology throughout her tenure at OMIC. Drs. Chamblee, Fouraker, and Merrill will be profoundly missed.

Finally, we extend our heartfelt gratitude to Drs. Ho Sun Choi and Michelle Ying for their years of service on OMIC Committees.

OMIC Board elects new Chair

We are pleased to announce that Dr. Robert Gold of Maitland, Florida, has been elected Chair of the OMIC Board of Directors beginning 1/1/2023.

MESSAGE FROM THE CHAIR

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To best be defended, surgical cases must be performed by an individual with the ability to handle the one in a thousand case. These skills are gained through years of instruction. Our education and training prepares us to respond to unexpected events. When I hear arguments or testimony that minimizes the risks of ophthalmic surgery, it's incredibly frustrating knowing this is dangerous and could likely result in injury and loss of vision. We must resist relaxing standards that will be difficult to defend in the courts and the court of public opinion.

As the largest insurer of ophthalmology, OMIC is also one of the largest insurers of optometrists, ophthalmic technicians, opticians, and ophthalmic physician assistants and nurses in America. Our insureds hire a well-rounded team to work in tandem and deliver the best care to our patients. They rely on OMIC to defend all providers aggressively as there have been significant claim settlements as a result of care provided by these staff members. Fortunately, OMIC wins most cases that go to trial and we close most claims with no settlement payment to plaintiffs.

Our fight now must concentrate on education, dialogue, and building alliances among all stakeholders. We must engage with our insured practices to discuss the pressures they face so that we may help them avoid pushing the envelope on patient safety. Ophthalmologists within larger group practices and private equity organizations must speak strongly in favor of this patient-centered approach. We will support our community with resources that are directed to all providers.

Let's consider any reasonable development of our insureds' eye care teams. Appropriate delegation is beneficial and we have added confidence in the people we hire, train, and supervise. Progressive responsibilities of these staff members will be essential as more patients enter the health care system. Education, training, and experience in a variety of chosen eye health care fields should be appropriately recognized.

OMIC is uniquely positioned to share with our practices what we see in our business. We must warn our insureds they may incur the full brunt of the backlash when poor results are showcased in the media and plaintiff attorneys exploit weakened or ignored patient safety standards.

I am optimistic that we can come together in solidarity to guide our profession through inevitable change. At OMIC we must serve our market and we know there is demand for increased efficiencies. Our insureds exist in a highly competitive and ever-changing environment. We all must adapt, and quickly.

As a leader of OMIC and the American Academy of Ophthalmology, I would like us to begin serious, thoughtful, and robust discussions about roles and responsibilities for eye care with all stakeholders. If we do not control the narrative as the captains of our eye care teams, then history will be written by those who are incapable of knowing what they simply do not know. Let's accept this challenge and shape our future through a series of state, regional, and national discussions. OMIC will be a leader as we've always been.

POLICY ISSUES

Liability and coverage for patient falls

KIMBERLY WYNKOOP, OMIC Vice President and General Counsel

Lawsuits and claims arising from patient falls present an evolving issue for plaintiffs, defendants, the court system, and insurance companies. If a patient sues an ophthalmologist or their medical practice or ambulatory surgery center (ASC), what legal theory applies? Is the claim one of medical malpractice (i.e., professional negligence) or ordinary negligence (e.g., premises liability)? This may appear to be a question of semantics, but the answer has important consequences.

Ordinary negligence occurs when a business or individual doesn't take the same amount of care any reasonable person would to avoid harming others. If others incur physical or financial harm because of the breach of this "duty of care," the business or individual can be held financially responsible. Professionals, hired for their specialized skills, are held to a higher duty or standard of care. They must use the same amount of care that others with their specialized knowledge and training would to avoid harming others; if they breach this duty it is called professional negligence. This applies not only to doctors but to other professionals like lawyers, accountants, and architects.

Medical malpractice is a type of professional liability for negligence that involves a breach of the standard of care in the performance of healthcare services. Premises liability is a type of general liability for ordinary negligence that occurs when an owner or possessor of property does not adequately protect people on the property, sometimes called "invitees," from hazards on the premises.

Courts across the United States have come up with different ways to determine if a claim is one of medical professional liability (MPL) or general liability (GL), though these "tests" aren't static and continue to develop. Some courts look at whether the defendant's conduct required the exercise of professional expertise, skill, or judgment. In Florida, for example, "professional services," from which professional liability stems, are considered to be business activities that involve specialized knowledge, labor, or skill and are predominantly mental or intellectual as opposed to physical or manual in nature. If the defendant's conduct didn't involve professional services, the claim would be considered one of general versus professional liability. Other courts reject this line of reasoning stating that healthcare providers perform both highly skilled and mundane tasks when rendering services, and that a breach when performing any such tasks would be considered professional liability. Some courts consider whether an expert witness would be necessary to explain the medicine or science to a judge or jury. If such an expert were necessary, the claim would fall under professional liability. Other courts look at the nature of the relationship between the premises or equipment at issue and the provision of care. If the equipment is necessary or integral to the medical treatment or diagnosis, they consider it an MPL claim. If the equipment is simply convenient for or incidental to the provision of medical care, they consider it a GL claim. Some courts focus on the responsibility of healthcare providers to offer a safe environment for diagnosis and treatment. If there are unsafe conditions that cause injury to a patient, even if these conditions could cause injury to any invitee, these courts would consider this professional negligence.

The ultimate outcome is often specific to the facts of a case. One consideration is where the patient was when the injury occurred, or, in the case of an ASC, if the patient had already been admitted. Falls in waiting rooms and public areas, like hallways and lobbies, and those of non-admitted patients, are more likely to be considered GL claims. Another consideration is whether something on the premises broke or malfunctioned versus whether the provider or employee failed to secure the patient; if the latter, MPL is more likely.

Why does it matter if a lawsuit is filed under a professional or ordinary negligence theory of liability? Most if not all states have different laws and procedures for malpractice and premises claims. For instance, an MPL suit may first need to be vetted by a medical review panel before it moves forward. Another difference is that the statute of limitations (the deadline for filing a suit) is generally shorter for MPL claims. In addition, many states cap the amount of damages that can be recovered in medical malpractice suits. The type of suit may also determine what discovery occurs and if expert witness testimony is required. It also impacts whether any settlement or judgment will need to be reported to the National Practitioner Data Bank; most MPL payments must be reported. Crucial for insurance purposes, the theory of liability will help determine what insurance is available to cover the claim and by which insurer(s). MPL policies generally do not cover injury due to unsafe premises or, more generally, injury that does not directly result from an act or omission in the provision of healthcare services, such as a failure to diagnose or an error made in surgical treatment. GL policies, on the other hand, often specifically exclude injury sustained during the delivery of healthcare, often under a "professional services" exclusion. As you know by now, state law varies, and different states evaluate insurance coverage in different ways.

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to the condition) with an interest in how a timely work-up could rule out "possible critical diagnoses with appropriate urgency."[2] Diagnosis ***process*** errors were evident in OMIC's GCA claims. Consider the following case, which settled for $600,000.

The event

A 60-year-old patient was hit on the right side of the head by a softball. One week later, they experienced headache, photophobia, flashes of white light, and dark spots OD. At the time the patient presented to an ophthalmologist, two weeks after the incident, they complained of constant headache. They denied jaw claudication. The patient was a smoker and took medications for Type II diabetes, DVT, and COPD.

Exam showed BCVA: 20/200 OD; 20/40 OS; VF: decreased inferiorly OD; pupils: very subtle APD OD; anterior segment: 2+ cataracts OU. The ophthalmologist's impression was branch retinal artery occlusion (BRAO) with disc edema OD. The plan was to recommend that the patient's primary care physician (PCP) order tests (ESR, FBS, CBC). The patient was also instructed to follow up with a glaucoma specialist to monitor for neovascular glaucoma risk.

The ophthalmologist notified the patient's PCP of the need for tests. When the patient saw their PCP the next day, they reported new loss of vision in the right eye. The PCP's note indicated that the ophthalmologist ordered tests to work up the patient's vision loss. The PCP's plan was to review all the ophthalmologist's notes; complete fasting labs for a diabetes and hyperlipidemia work-up; and order a carotid ultrasound and an X-ray for neck pain associated with headache. The PCP instructed the patient to follow up with both the PCP and the ophthalmologist in one month. Three days later, the patient awoke with poor vision OS and worsening vision OD. The patient returned to the ophthalmologist's office and was seen by an associate. At this visit, the patient reported weight loss and jaw claudication on both sides. VA: HM OD; 20/100 OS; pupils sluggish OU; fundi: marked pale disc edema with some vascular dilation OU. The ophthalmologist confirmed GCA.

Comment

Given the patient's history of headache and the exam findings, a more detailed review of systems to address GCA symptoms (e.g., temple/scalp tenderness, fever, weight loss, etc.) could have been performed at the initial appointment. In addition, there was a lack of urgency with which the evaluation was performed. Expert reviewers felt that the ophthalmologist should have personally ordered the tests (including a CRP), rather than recommending that the PCP do it.

Experts also cited documentation deficiencies. Despite the softball injury (a red herring), the patient's history, exam findings, and clinical course were highly suggestive of GCA, and GCA continued to be recorded as a possible diagnosis throughout the record. The physician's decision making relative to these findings was not evident in the medical record. Initial labs were not in the chart; temporal artery biopsy results were negative, but not included in the chart; and there was no evidence of direct communication between the ophthalmologist and the PCP.

Problems eliciting a thorough and accurate history

Prompt diagnosis of GCA depends upon the thoroughness and accuracy of the health history. Obtaining an accurate history can be challenging for several reasons:

1. Patients often report their history differently to each healthcare provider, based upon the questions asked, the time spent gathering the information, and many other factors; as a result, another physician sometimes obtains the more thorough history.

2. Patients presenting with eye complaints often do not think that it is important or pertinent to tell their ophthalmologist about non-ophthalmic problems they are experiencing, such as jaw pain when chewing, fatigue, or weight loss. Consequently, ophthalmologists may learn only about the patient's vision complaints and headache, while other physicians may obtain other information, such as the duration or quality of the headache and the existence of jaw pain.

3. In addition to vision loss, headache, jaw pain, fever, and scalp tenderness, varied and non-specific constitutional symptoms, such as fatigue, malaise, and weight loss, may develop over time.

4. Information can slip through the cracks if the ophthalmologist doesn't review the notes that staff took during the initial work-up and intake, in which they may have obtained and documented the presence of GCA symptoms. Without this additional information, an ophthalmologist may not consider GCA in the differential diagnosis.

Risk Management Recommendations

*√ **Aim for specificity.** For example, with a patient complaining of a headache spanning two days and a "curtain" over their vision, the ophthalmologist can gain valuable information by asking more about the precise nature of that "curtain" (e.g., transparent, dark).*

*√ **Ask the right questions.** In addition to eliciting accurate information about the patient's eye complaint, query older patients about constitutional symptoms. A careful review of signs, symptoms, and systems can help distinguish the few patients who could have GCA from the large number of older patients with more common eye problems seen daily in ophthalmic practices. Don't wait for the patient to offer the information; ask for it.*

*√ **Use a checklist.** OMIC's sample "GCA Checklist" is available at: http://www.omic.com/giant-cell-arteritis-toolkit/ The checklist will prompt you in obtaining information to build a more thorough history and offer cues to take action.*

Time is of the essence

The short window for diagnosing and addressing GCA is made clear in the following example.

The event

An 84-year-old patient presented to their ophthalmologist with a five-week history of lymphadenopathy and

headache with transient monocular vision loss OD. The ophthalmologist told the patient that they might have a brain tumor and referred them to a neuro-ophthalmologist for an appointment two weeks out. The patient requested a sooner appointment. The office tried to schedule a same-day appointment with a different neuro-ophthalmologist, but the patient had a conflict that day. The patient woke up the next day with total vision loss OD and went to the ER. The patient was admitted and treated for seven days with IV and oral steroids for presumed temporal arteritis. The patient was seen by a neuro-ophthalmologist. A temporal artery biopsy was positive for GCA.

Comment

Although the defendant ophthalmologist recognized an urgent problem, they did not treat it as an emergency. Immediate referral for further evaluation and management with high-dose corticosteroids was indicated. The defendant was also criticized for not considering GCA. In addition, the ophthalmologist needed to inform the patient of the consequences of not getting the emergency evaluation (i.e., an "informed refusal" discussion), and document that discussion in the record. This case settled for $750,000.

Risk Management Recommendations

*√ **Assume the worst.** When a patient presents with vision changes, headache, jaw pain, fever, and scalp tenderness, the treating physician should always consider the worst possible diagnoses and develop a plan that rules out those diagnoses. Giant cell arteritis, which could lead to blindness, would be among those diagnoses.*

*√ **Gather information.** This is needed to make the diagnosis or rule it out. Knowing what information to seek will guide you in taking the history, performing the exam, ordering studies, and requesting consultations.*

__Use__ OMIC's sample "GCA Checklist" to support information gathering.

__Ensure__ that you know where and how to access information in the EHR (e.g., referral requests; studies ordered by the ER and other physicians; notes made by staff).

__Remember__ that gathering information from the patient over the phone has limitations and invites the risk of delayed diagnosis.

__Obtain__ a careful history when taking after-hours calls and document your discussion. If your staff screens after-hours calls, develop and implement a formal telephone screening protocol to avoid staff practicing outside of their scope. See: "Telephone Screening of Ophthalmic Problems" at: http://www.omic.com/telephone-screening-of-ophthalmic-problems-sample-contact-forms-and-screening-guideline/

*√ **Communicate clearly.** Patients often do not appreciate the potential seriousness of their condition and, therefore, delay seeing the physician.*

__Verify__ patient understands concerns about potential for vision loss.

__Explain__ to the patient that GCA can progress rapidly and lead to bilateral, irreversible, blindness.

__Give__ the patient information on exactly what signs and symptoms to watch for and instruct them to contact you as soon as they notice any changes. (See OMIC's "Giant Cell Arteritis: Patient Information Sheet," available at: http://www.omic.com/giant-cell-arteritis-toolkit/

__Document__ these discussions and the patient's understanding, especially any patient refusal to follow recommendations.

__Write__ explicit orders for nurses, whenever a patient is hospitalized, regarding signs and symptoms you want reported to you at once.

__Share__ your decision-making process and differential diagnosis with others (e.g., ER physicians, consultants, the patient's primary care physician).

*√ **Document your decision-making process.** This is crucial for both continuity of care, and to defend your actions should your care be questioned later.*

While ophthalmologists do not explicitly use a __SOAP__ format in their charting, the model can prompt you to document meaningful information:

__Subjective.__ When possible, use the patient's own words to document the presenting complaint, including onset, severity, duration, how it affects vision, and whether the patient has contacted another healthcare provider about it.

__Objective.__ Document the history, exam, and diagnostic process. Chart all pertinent positive and negative findings. OMIC's sample "GCA Checklist" can help with this.

__Assessment.__ Include your differential diagnoses.

__Plan.__ Include further diagnostic work-up, treatment, follow-up plans, and any instructions given to the patient about when to call you and when to return.

*√ **Be aware of some warning signs of a missed diagnosis.***

The diagnosis does not account for all symptoms and findings.

Your decision-making process did not rule out worst-case scenario.

The patient is not responding to treatment.

The patient has a new, evolving, or recurring complaint.

The patient makes repeat visits or phone calls to you, or calls multiple providers.

*√ **Continue to pursue diagnosis.***

Obtain records from other providers.

Read all prior chart notes.

Account for all symptoms and findings.

Ask for consultation or referral as needed.

Office systems and coordination of care

Systems issues include poor or inconsistent communication (between physicians and patients, physicians and staff, and staff and patients); faulty coordination of care; inadequate supervision; problems with information management (EHR); and poor tracking of test results. These issues played a part in the following case, which settled for $350,000.

The event

A 74-year-old patient, with a history of headaches and intermittent vision loss OS, went to the emergency room for evaluation of vision loss. The work-up for TIA was negative.

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CLOSED CLAIM STUDY

Failure to diagnose Giant Cell Arteritis results in settlement

RYAN M. BUCSI, OMIC Claims Vice President

Allegation

Failure to diagnose giant cell arteritis in a 79-year-old.

Disposition

Settlement of $475K.

A patient with a history of 1.5 days of blurry vision and diplopia with pain OD was referred to an OMIC insured by their primary care physician (PCP). The insured examined the patient one day after the referral. The patient complained of a two-day history of visual distortion OD, pain OD, diplopia, and a loss of vision for three minutes OD. The VA was 20/25 OU, with a normal reactive pupil. Visual fields were full to confrontation, the anterior segment exam was remarkable for bilateral pseudophakia, and the dilated fundus exam was normal. The ocular motility exam was remarkable for bilateral "6 PD of esotropia and PD of hypophoria" with normal versions. The impression was diplopia, right esotropia, history of right facial pain, loss of vision briefly yesterday, questionable dilated pupil yesterday, no carotid bruit today, and questionable difficulty with gait today. The insured recommended an MRI and contacted the patient's PCP by phone to arrange for neuroimaging. The insured advised the patient to return for prism glasses if diplopia persisted. The following day, the patient went to the emergency room complaining of worsening vision, with a "horizontal bar" blocking the right eye. The patient also reported a right-sided headache, vision loss, and tenderness overlying the temporal artery region. An ESR was 102. Symptoms suggested temporal arteritis. One gram of solumedrol was administered in the emergency room, an additional two days of solumedrol was prescribed, followed by 60mg of prednisone per day. MRI results were described in the setting of giant cell arteritis, and the diagnosis was confirmed via temporal artery biopsy the following day. Five days later, another ophthalmologist indicated that two days following the emergency room examination, vision was lost OD and vision OS was dropping. Upon last examination by the insured's partner, the patient's vision was NLP OD and LP OS.

Analysis

Plaintiff's expert testified at deposition that the OMIC insured deviated from the standard of care by failing to obtain an accurate and complete medical history, and failing to place GCA high on the differential diagnosis, order appropriate tests, and immediately start the patient on high-dose steroids. The plaintiff's expert also criticized the insured for failing to immediately transfer the patient to a facility where treatment could be initiated. Given the elderly patient's history of headache and transient vision loss/disturbances, the insured was obligated to ask targeted questions to rule out GCA as the cause. Had steroids been started on the morning of the insured's examination, the expert opined that there was a reasonable chance vision loss could have been prevented OS and possibly OD. The expert based this opinion on the fact that the patient did not lose vision OD until two days after the insured's exam and did not lose vision OS until seven days after the insured's exam. OMIC's retained defense expert's opinions did not differ significantly from the plaintiff expert's opinions. OMIC's three retained experts believed that a sedimentation rate should have been ordered to rule out an inflammatory process/temporal arteritis based on the reported loss of vision for three minutes. OMIC experts commented that they would have also ordered a CBC and a C-Reactive Protein test. There was no debate among OMIC's experts that care provided to the patient was below standard of care. The patient should have been immediately referred by our insured to the emergency room, since the earlier the treatment is initiated with steroids to keep the lumen of the vessels open for blood flow, the better the outcome.

Takeaway

OMIC has seen several sizeable settlements resulting from failure to diagnose giant cell arteritis cases in the past few years. In 2020, alone, there were two large settlements, this one for $475K and another case for $600K. The settlements are large because GCA, if diagnosis does not occur or is delayed, often leads to bilateral blindness in elderly patients. OMIC's claims related to GCA have and continue to be problematic and are extremely difficult to defend in front of a jury. As a result, OMIC has developed a sample "*GCA Checklist*" http://www.omic.com/giant-cell-arteritis-toolkit/ as a risk management tool to help ophthalmologists screen patients for giant cell arteritis and document that evaluation. OMIC is hopeful that insureds' use of this checklist, along with their clinical judgment, can improve the timeliness of GCA diagnoses and decrease the risk of resulting lawsuits and settlements.

DIAGNOSTIC PROCESS

What's in your toolbox?

JANE MOCK, CPHRM, OMIC Risk Manager

Think about how you employ heuristics in working up patients. Heuristic thinking is based on past experience, and uses mental shortcuts, intuition, and "rule of thumb" to solve problems and make judgments quickly and efficiently. It's generally used when physicians see a patient with a familiar set of symptoms that fit a recognizable diagnosis.[1]

Heuristics can be useful, but they can also cause physicians to respond with cognitive biases (e.g., anchoring, ascertainment, availability, confirmation, diagnostic momentum, hindsight, and more) that lead to diagnostic error. In their 2018 article, "Clinical Decision-Making: Heuristics and Cognitive Biases for the Ophthalmologist," the authors, Hussain and Oestreicher, observe that ophthalmologists encounter different diseases with similar clinical presentations, and that these are situations in which heuristics can fail.[1]

***Consider** the ways in which symptoms such as vision change and headache, might, when using "fast thinking," put you at risk for missing a GCA diagnosis. Be aware of the vulnerabilities of heuristics and have strategies to complement this style of thinking; for example, employing analytic ("slow") thinking, which accounts for evaluating information collected from the patient and interpreting symptoms.*

Reference

[1]Hussain A, Oestreicher J. Clinical decision-making: heuristics and cognitive biases for the ophthalmologist. *Survey of Ophthalmology* 2018;63:119-124. Available at: http://www.surveyophthalmol.com/article/S0039-6257(17)30115-7/fulltext#relatedArticle (Accessed: 6/10/22)

Hussain and Oestreicher write that cognitive errors leading to incorrect diagnoses are not as much about knowledge deficiency, as they are about problems collecting, integrating, and verifying data. The authors note that these particular gaps lead to "premature diagnostic closure," where the "thinking stops" once the diagnosis is made.[1]

***Consider** whether you've had difficulties in the collection, integration, and verification of data. Under what circumstances does this occur (e.g., gathering information from the patient or other healthcare providers; locating information in the EHR; being able to think about information critically), and can you make changes in the practice to improve processes?*

References for *Giant Cell Arteritis*

[1]ECRI and Institute for Safe Medication Practices (ISMP). Top 10 Patient Safety Concerns 2022. Available at: http://www.ecri.org/top-10-patient-safety-concerns-2022 (Accessed: 6/10/22)

[2]Muro-Fuentes EA, Stunkel L. Diagnostic Error in neuro-ophthalmology: avenues to improve. *Curr Neurol Neurosci Rep.* 2022 Apr;22(4):243-256. Available at: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC8940596/ (Accessed: 6/10/22)

RESOURCES

Home Study

For a complete listing of current recordings and computer-based courses available for OMIC insureds, visit **omic.com/risk-management/education/online-and-recorded-courses**.

Live Seminars

OMIC will conduct live courses again when it is safe to do so. A listing of upcoming courses will be posted at **omic.com/calendar**.

Partnerships

OMIC has partnerships with most ophthalmic societies in the United States. Learn more at **omic.com/partners**.

Alerts and Bulletins

OMIC posts recommendations for responding to recalls and alerts. For a complete archive visit **omic.com/risk-management/digests-alerts-and-bulletins**.

OMIC Library

For a complete online library of forms, documents, and recommendations, visit **omic.com/risk-management.**

OMIC Risk Managment Hotline

OMIC's confidential risk management hotline is available for insureds who need risk management assistance. Call (800) 562-6642 and Press 4 for the risk manager on duty. Message the hotline at **riskmanagement@omic.com**

AAO Store

The AAO store has excellent patient education videos on a variety of topics. Vsit **store.aao.org.**

Giant Cell Arteritis

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Chest x-ray, angiogram, and head and neck CT were all negative. There was no afferent pupillary defect, and intraocular pressures were normal. Eye ultrasound revealed signs of retinal or vitreous detachment, and the ER physician obtained a phone consultation with an ophthalmologist. The ophthalmologist recommended the patient come to the office first thing the next morning.

The patient presented to the ophthalmologist's office the following afternoon and was seen by an optometrist. The optometrist didn't have access to the test results from the hospital. The OD documented that the patient had several episodes of blurry vision in the right eye and intermittent vision loss OS. The OD thought there might be a problem with blood flow to the eye, diagnosed dry eye, and prescribed drops. The OD recommended that the patient follow up with their PCP and transmitted the visit notes to the PCP's office.

The patient continued to experience worsening vision over the next two weeks. It is unclear whether the patient returned to see the ophthalmologist; however, the patient spoke with another optometrist in the practice about what to do if symptoms persisted. The patient testified that they were told not to worry if their vision was just blurry. They were told to continue with the artificial tears and go to the ER if it got worse. The patient was told that if they wanted to be seen, they needed to come to the office by 9 a.m. The patient reported feeling discouraged by the response, and didn't go to the office the next day, but did return to the ER. The ER physician suspected GCA and began steroids. A temporal artery biopsy confirmed GCA.

The patient's lawsuit alleged failure to perform a proper evaluation, order appropriate tests, perform a temporal artery biopsy, arrive at a differential diagnosis, and properly coordinate follow-up care, as well as scheduling with an optometrist rather than an ophthalmologist.

Comment

Experts felt that the ophthalmologist had limited responsibility after taking the initial phone call from the ER, and neither the ophthalmologist nor the optometrist had accurate information from the ER to make the correct diagnosis.

Takeaways

The optometrist should have considered GCA in a patient over age 50 with a two-week history of headache and vision changes. The OD should also have asked GCA-related questions, which might have led to a high index of suspicion for GCA, and should have checked the labs that were done in the hospital. The second optometrist whom the patient saw two weeks later also failed to ask GCA-related questions.

The office had a policy to schedule on-call patients in a morning slot reserved for them; however, staff scheduled this patient in the afternoon, which may have not prompted the optometrist to have that increased index of suspicion.

Risk Management Recommendations

*√ **Track your patient.** Keep diagnosis and treatment from falling through the cracks by having a robust office follow-up system.*

A follow-up system helps you monitor diagnostic procedure results, patient compliance with treatment recommendations, and appointments. Create a tracking system for:

- ***Patients you send for consultations and referrals***
- ***Diagnostic tests and procedures performed by other providers***
- ***Requests for consultations/referrals from the ER and other providers***
- ***Missed or canceled appointments (ideally, schedule patients before they leave the office)***

Conclusion

The combination of incomplete history, poor coordination of care among providers, and office systems issues is a common theme in GCA claims. Ophthalmologists can take steps to reduce the likelihood of delayed diagnosis of GCA and subsequent claims. Key among these steps is proactively obtaining a more thorough history to improve the likelihood of including GCA in the differential diagnosis when older patients present with vision changes. OMIC's sample "*GCA Checklist*" http://www.omic.com/giant-cell-arteritis-toolkit/ can prompt such questions and help track completion of key tests and consults.

References for Giant Cell Arteritis on page 7

Liability and coverage for patient falls

continued from page 3

Some states use the "four corners doctrine." This means that courts compare the language of the insurance contract and the allegations in the lawsuit to determine if there is a duty of the insurer to cover the claim. In other states, courts look beyond the allegations in the lawsuit and also consider facts known or apparent to the insurer at the outset of the case. They argue that a liability insurer should not be relieved of its duty to defend a claim merely because the plaintiff in the underlying lawsuit didn't plead his or her claim well. This means that, while the allegations in the complaint alone often indicate if an insurance policy should cover a claim, in some states there may be additional information to consider. When a suit has not yet been filed, insurers must look at the allegations in any written demand and the facts of the situation to determine whether an insurance policy applies.

Some carriers, like OMIC, include limited office premises liability insurance in their professional liability policies. In OMIC's case, we offer $50,000 in premises liability coverage. However, if the insured has GL coverage for a premises liability claim, OMIC's limited coverage is not available. OMIC's $50,000 is a safeguard in the unlikely event that premises liability coverage is not available elsewhere; but when it is, the carrier specializing in that line of business is in the best position to defend and pay the claim. In fall-related claims, since it is not always clear (especially before a lawsuit is filed) whether the legal basis for the claim is professional or ordinary negligence, OMIC often must coordinate with our insureds' GL carriers. OMIC recommends reporting these claims under all potentially applicable policies.

Notice: Office premises liability coverage is not available to OMIC insureds participating in the Kansas Health Care Stabilization Fund and the Nebraska Excess Liability Fund.

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