Emergency Triage – Protecting the Patients and the Practice

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On a typical day the average optometric office likely receives fifty or more phone calls. The topics range from requests to schedule an appointment, calling about a bill, asking if the doctor is “in the insurance plan,” or how much are contact lenses? But on one day in an optometric office, the finder of fact – the jury- found that when the plaintiff called her optometrist’s office and described her symptoms, it was the receptionist, answering the phone, in failing to take the proper action by seeking an immediate appointment, whose conduct led to the plaintiff’s permanent partial loss of vision. Under respondeat superior, Latin for “let the superior answer.” the optometrist may be held liable for his staff’s responses to phone inquiries.

The former receptionist said that she was new to the job and was not adequately trained. I did talk to the fellow attorney who “won” the case and he told me part of the “win” was because the optometrist, the receptionist, and the office did not convey the “professionalism” needed to handle medical urgencies.

If you are wondering how a phone call without seeing the doctor and not receiving payment can set the office up for malpractice - it has to do with a breach of duty that the optometrist had to the caller. Under tort law if a person or entity has an obligation or a duty toward another and this duty is inadequate that duty is said to be breached. A defendant will not be liable unless the plaintiff is owed a duty of care. An optometrist, who holds himself or herself out as a health care provider, does have the responsibility to recognize an eye emergency and respond in a manner that will facilitate proper protocol under that circumstance.

In an article in Medical Economics, October 10, 2011, titled “PA’s and malpractice” the authors list in a table the “Characteristics of claims and suits brought against physician assistants, 2002 to 2009.” The median amount given for total settlement was $200,000 for physicians and $100,000 for physician assistants. So even with direct supervision of the physician the physician assistant can also be liable. The MD is liable for the PA as long as the PA is acting within the line and scope of the PA’s duties. Although both MD and PA are sued and held liable; it is the MD’s insurance that pays the claim. PA’s typically do not have their own insurance. In some optometric offices paraoptometric assistants are not utilized. However, as you can see, direct supervision does prevent lawsuits even when paraoptometrics are utilized.

To find fault under a negligence claim there should be four elements present:

1. The optometrist owed a duty of care.
2. The optometrist provided inadequate care or breached that duty of care.
3. That breach caused or proximately caused an injury.
4. The injury was found to result in monetary compensation.
To win this case, the plaintiff’s attorney had to prove to the jury that the optometrist first had a duty to the caller and that this duty was breached, or put another way, the optometrist was negligent in handling that emergency. And “but for” this negligence the plaintiff would have sought immediate treatment and would not have lost part of her vision. The jury found that the optometrist’s failure to see the plaintiff, acting through the receptionist, was to proximately resulted in, of the woman’s loss of vision.

The plaintiff in this case was a “high” myope. Although “high” myopia is a clear risk factor for a retinal detachment, at what refractive error does the person have to be to be considered a “high” myope? A myopia of 6 diopters is clearly “high” according to the article “Too Little, Too Late” by Jerome Sherman, Optometric Management, November 2001. In the case referenced above the plaintiff’s attorney, asked the optometrist if he could tell the jury at what number would the doctor feel there would be a risk for a retinal detachment. And according to the attorney, the optometrist did not answer this question in a manner beneficial to himself. Regardless, even if the person’s Rx is unknown, if the phone rings and the person on the other end is stating that she has just started to see floaters, a spider-like black spot, a veil over one of her eyes, shooting stars or just noticed one eye is now very blurry, immediate diagnosis and treatment is essential along with appropriate documentation of the call.

The symptoms were described as: “While at a restaurant the room began to swarm with insects and drifting bits of yarn. A moment later, I realized they were actually inside my right eye – a mini-avalanche of the spots that doctors call floaters.”

Jane E. Brody writing in the New York Times describes a retinal detachment as follows: “Retinal detachment is painless but nearly always causes symptoms, often before the detachment starts: a sudden appearance of many ‘floaters’ – spots, hairs or strings - in your vision; sudden brief flashes of light even when your eyes are closed; or a shadow over part of your visual field.”

If a caller describes any of the above they may be describing a retinal detachment. A retinal detachment is a true emergency and a delay of treatment that results in worsening of the detachment is negligence.

In an article that appeared in the Archives of Ophthalmology, “Ophthalmic Malpractice Lawsuits With Large Monetary Awards”, the most common complication of treatment was reported to be failure or delay in the diagnosis of a detached retina (25%).

The article “Malpractice payments by optometrist: An analysis of the national practitioner databank over 18 years” written by Drs. Duszak and lists the major categories. By far the largest category is “failure to diagnose”, followed by “delay in diagnosis,” “wrong or misdiagnosis,” “improper management” and “failure/delay in referral or consultation.”

If a patient conveys to you, whether in person or on the phone, a possible sight or life-threatening symptom, immediate and correct response is vital.

**What is Triage?**

Triage is a system of sorting and assigning priorities for medical treatment based on the urgency of the symptoms. An emergency telephone triage form will ensure the paraoptometric answering the phone will collect the necessary information to determine what an emergency is and how soon the patient will need treatment.

When a call is received, and the person wants to make an appointment, ask if this is an emergency. If the answer is yes, inquire more deeply about the nature of the emergency.
Some additional questions to ask would be:

- What kind of problem are you having? (chief complaint)
- How long has it been going on? (onset/duration)
- Is it getting worse? (severity)
- How does it affect your vision? (associated symptoms)
- Does anything make it better? (modifying factors/relief such as wearing glasses)

If you are not sure after you receive additional information, you must relay to the optometrist the details of the phone conversation, but before putting the caller on hold remind the person that if this is a true emergency (such as a chemical splash or total blindness in an eye) he or she should go to the emergency room or, the closet skilled ophthalmologist.

The first person answering the phone in the optometrist’s office is the most important person when it comes to ocular emergencies. Asking a series of questions may prevent the caller from going blind and prevent a possible malpractice claim, especially if the patient’s illness or injury is treatable. An optometrist can be held responsible for a delay of proper treatment.

There are triage categories that help assist in making the determination when the appointment is made or if immediate assistance is necessary. The categories are:

- Emergency- must be evaluated immediately
- Urgent – must be seen within 12 to 24 hours
- Routine- to be seen at next available appointment time

An ocular emergency report form is helpful to ask the correct questions, and for accuracy in documenting the call. The form may include special questions: when was the date of the first symptom, was the onset sudden, what do you see, are there floaters or flashes of light, was there a recent injury, recent eye surgery, do you have hazy vision or is part of your vision blurry?

Do not offer the patient a diagnosis or give an opinion on a condition over the phone.

An important aspect of the case, described earlier, was that the jury believed the plaintiff and not the optometrist about whether a return call was made to the patient. In Dr. Allen’s article, “Retina Claims Pay Fewer But Costlier Indemnities,” (www.omic.com/resources/risk_man/deskref/clinical/48.cfm) under the subheading, “Dropping the Ball Post Op,” the doctor said he told the patient to come to the office the next day but comment was not documented. Unfortunately, the doctor was sued and the case was settled because the plaintiff appeared to be a “very credible and sympathetic witness.” To avoid this, document the call and what was recommended.

Delays in retinal detachment treatment are not the only symptom-based phone inquiries that can lead to a malpractice claim. Here are a few examples:”

- “My eye is red!” This is a complaint that could be an emergency if the “red” is really an interior eye hemorrhage and failure to diagnosis this could lead to elevated intraocular pressure and loss of vision. Or the red eye can rapidly result in permanent vision loss due to scarring.
- “Suddenly, I cannot see as clearly as before” or “I woke this morning and now I see double!” This may be hemorrhage in the eye, optic nerve disease, a stroke, or another potentially devastating disease. Either see this patient or send the person to the emergency room as soon as possible.
• “My upper lid appears swollen and it feels warm to the touch.” See this person that day, most likely, the person will need oral antibiotics. If the infection becomes systemic, serious injury can result.

• “I just broke my glasses and I one need to drive” If your office has one day service you should attempt to assist the person who has lost or broken eye glasses, but advising a person with unaided acuity to drive may be very hazardous.

The newer software programs connecting the Electronic Health Record to the schedule prompts the receptionist to ask why an appointment is being made. This should help differentiate the more routine visit from the true emergency.

Be cautious if you write “no problem,” “yearly visit” or “routine care” on the form even if the caller states it is a routine visit. Their perception of what is routine may be different than the standard reply. They may have insulin dependent diabetes, be a glaucoma suspect or have early Age Related Macular Degeneration and still state that it’s “routine.” Such wording may also affect insurance reimbursement.

A patient reporting pain or vision loss is an emergency, and every attempt must be made to get the patient into the office for an evaluation. Always consult with the doctor when in doubt. It is better to be on the side of safety rather than sorry, not only for the patient but also for the practice.

Dr Fleming is a graduate of Salus University, P.C.O.. She attended Rutgers School of Law, and earned a Juris Doctor degree in 2006; Fleming has served as a Past N.J. Society of Optometric Physicians Board of Trustee member; Past South Jersey Society of Optometric Physicians President; and Past member of the N.J. regulatory State Board of Optometry. Fleming currently is a member of the A.O.A., N.J.S.O.P. and the N.J. Academy of Optometry. Fleming supports the efforts of the AOA PAC by being a Presidential Level donor. Dr. Fleming resides in New Jersey and is married with two children. Dr Fleming enjoys traveling with her family and playing golf.

2 Medical Economics, Matt Ledges, MD, Ms, PA; Michael Victoroff, MD; and Adit A Ginde, MD, MPH, October 10, 2011.
6 “Ophthalmic Malpractice Lawsuits With Large Monetary Awards,” Archives of Ophthalmology, Vol 114 No 3, March 1986
Emergency Triage – Protecting the Patients and the Practice Quiz

To receive one hour of continuing education credit, you must be an AOA Associate member and answer seven of the ten questions successfully. This exam consists of multiple-choice questions designed to measure your level of understanding of the material covered in the continuing education article “Emergency Triage – Protecting the Patient and the Practice.”

Expiration Date: Dec. 31st of this year

To receive continuing education credit, complete the information below and mail with your $10 processing fee, ($10 per hour of CE) before Dec. 31st of this year to the:
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Select the option that best answers the question.

1. People who experience retinal detachment complain of the following:
   a. Pain
   b. Fever
   c. Nausea
   d. Visual disturbance

2. If we do not accept the caller’s insurance we do not have an obligation to worry about their stated symptoms?
   a. True
   b. False

3. Can the doctor be sued for staff negligence?
   a. Yes
   b. No
4. Documentation of the phone call is important for the following reasons.
   a. Have a written record of the patient’s complaint
   b. Legally this would support what was said.
   c. If the symptoms worsen this would document the status at the time of the call.
   d. All the above.

5. Malpractice is NOT when:
   a. The optometrist owes the person a duty of care
   b. The optometrist directly or indirectly breaches this duty of care.
   c. The breach proximately did not cause injury.
   d. This injury is serious enough to justify monetary compensation

6. Triage is a system of sorting and assigning priorities for medical treatment based on when patients arrive at the practice with symptoms?
   a. True
   b. False

7. A complaint of a puffy lid is important for the following reasons:
   a. The cause can be life threatening
   b. This is a billable code.
   c. The cause is likely lack of sleep and not to worry.
   d. Puffy lids are allergy related.

8. A complaint that a swollen lid is warmer than usual should prompt the following except:
   a. Make an immediate appointment.
   b. If the optometrist is on vacation send the person to the emergency room or a colleague who can see the patient immediately.
   c. Tell the person to use a bag of frozen peas to reduce the swelling and call in 1 week if not better.
   d. Document the call: include recommendations, date, time and names.
9. Which is not a triage category:
   a. Immediate
   b. Emergency
   c. Urgent
   d. Routine

10. The use of a triage Emergency form helps:
   a. Document the call
   b. Determine what the emergency is
   c. Determines how soon the patient will need treatment
   d. All of the above

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