Lessons Learned From A Case of Endophthalmitis

Although fellowship training prepares the specialist for when things go wrong, the first time it happens can be an unsettling prospect.

By Allen Chiang, MD

Editor's Note: New Retina MD *is pleased to introduce a new feature in the magazine spearheaded by Allen Chiang, MD, a retina specialist with Wills Eye Hospital and Mid Atlantic Retina in Pennsylvania, New Jersey, and Delaware. This feature column will look at the issues that newly practicing retina specialists—in their first 5 years of practice—may not have learned in residency or fellowship. As Dr. Chiang explains in this poignant introduction to the column, "… the journey after the conclusion of formal training is laden with numerous real-world obstacles and hurdles. Yes, the learning curve is steeper still."*

–Bryan Bechtel, Editor-in-Chief

My smartphone buzzed and rattled in my coat pocket. I glanced at the caller ID—it was one of my partners calling to inform me that a patient I treated with an anti-VEGF agent 2 days prior had presented unexpectedly with acute vision loss. "Unfortunately, it looks consistent with infectious endophthalmitis," he said flatly. As we hashed out the treatment plan, I felt my heart sink.

Endophthalmitis. The statistics had finally caught up with me.

During a systematic debriefing with my staff, I learned that there was evidently no deviation of our injection protocol, no issues with this particular batch of drug, and nothing uniquely different about this particular patient or injection compared to countless others. Taking into account all of the intravitreal injections I have done over the past few years, I realized that I was right on par with published rates. Yet, I found no consolation in statistical analysis. This patient had presented with severe central retinal vein occlusion–related macular edema and had been absolutely thrilled with his improvement from 20/100 to 20/30 visual acuity. Two days ago he was beaming and grinning widely. I shuddered to imagine his facial expression now.

THE LESSONS LEARNED

We are fortunate to be practicing retina in a truly extraordinary era. Anti-VEGF medications have empowered us to make a profound impact on patients' lives, enabling many to see well enough to continue living independently. However, the inherently repetitive nature of anti-VEGF therapy can sometimes lull physicians and patients alike into either trivializing the procedure or assuming that certain things either will or will not happen. It is important to stay vigilant when things are going smoothly and to be systematic when things get turbulent. Here are a few practical considerations I gleaned from this experience:

"Taking into account all of the intravitreal injections I have done over the past few years, I realized that I was right on par with published rates. Yet, I found no consolation in statistical analysis."

1. Debrief and Review

After any airplane crash or a near miss, the Federal Aviation Administration conducts an investigation to scrutinize the systems and all parties involved. General surgeons do something similar during morbidity and mortality, or M&M, conferences. Once problems are identified, either new policies can be created or existing ones can be amended to mitigate future risk. In some instances, the investigation may simply confirm that existing systems are functioning satisfactorily.

I experienced firsthand the value of engaging in a debriefing process with my office manager, ophthalmic technicians, and colleagues. I was pleasantly surprised to find that my staff shared my depth of concern for the patient; many, in fact, had lost sleep over this incident. The simple act of sitting down at a table to debrief and review our clinical protocols proved to be invaluable. It reassured us that we have a sound and well-functioning protocol and gave us an opportunity to brainstorm new ideas to improve upon patients' experiences. It boosted staff morale because it generated dialogue, and the debriefing emphasized that a work environment with open lines of communication is essential to our

mission to serve patients with skill and compassion. While it can be tempting to delegate this to a practice administrator or operations manager, I learned that a physician-led debriefing generates the most positive energy and delivers the greatest impact.

2. Confer With Experts

Risk management is an important component in dealing with any unexpected outcome. Despite a thorough informed consent process, patients are individuals and will process unexpected outcomes uniquely. From the experience with my first case of endophthalmitis, I learned that the way in which a patient and their family respond may be more unpredictable than the unfortunate occurrence itself.

Much of what we do in retina is highly interventional. It is good practice to have a game plan, or at least an established channel of communication with legal counsel or a similar resource to aid with risk management when difficult situations arise. My colleagues and I have found Ophthalmic Mutual Insurance Company (OMIC) to be an invaluable resource. For OMIC policyholders, there is a risk management hotline available via the OMIC website that provides a confidential conversation with a risk management specialist who can help one navigate through unexpected outcomes, difficult patient encounters, documentation issues, etc. Do not assume that you have everything in order or rely on the well-intentioned advice of colleagues alone—seek expert counsel.

3. Be There

When you and the patient run into a bad and unexpected outcome, it is critical to remain present for him or her as a trustworthy friend would. This was the advice I received from mentors when I was a fellow, and its significance cannot be overemphasized. It is anything but easy, particularly in a case of endophthalmitis when the patient will be back for numerous visits and the long-term outcome is unknown. Staying actively involved in a patient's follow up during these stressful situations requires time, empathy, perseverance, and fortitude—all of which are demanding yet promote healing.

From a practical standpoint, I have found a few things to be particularly helpful. The first is to arrange for courtesy transportation for the patient who lives alone or has difficulty securing a ride to maintain the close follow-up that will be necessary in the immediate term. The second is to inform your front desk and staff to flag the patient's chart so that he or she is expedited on every follow-up visit. The third is to engage and maintain communication with the patient's family members early on. A majority of patients with retinal disease are elderly and in many cases the situation is almost the reverse of what pediatricians encounter—instead of dealing with the parents, we are often dealing with the patient's adult children. The fourth is to strongly consider waiving or at least putting a hold on out-of-pocket costs. For a patient who is trying to cope with an unexpected outcome, receiving unanticipated bills or having to pay the copay for daily visits can only serve to aggravate things further.

> "Those who are currently in the first 5 years of practice have undoubtedly realized that a fellowship certificate is akin to a driver's license—it is just the beginning."

CONCLUSION

Those who are currently in the first 5 years of practice have undoubtedly realized that a fellowship certificate is akin to a driver's license—it is just the beginning. Although we worked tirelessly in fellowship to attain a broad knowledge base and sound surgical skills, the journey after the conclusion of formal training is laden with numerous real-world obstacles and hurdles. Yes, the learning curve is steeper still.

While I had participated in managing numerous cases of endophthalmitis during my training, wrestling with infectious endophthalmitis for the first time in my very own patient served as an especially poignant reminder of the gravity of the work we do in our medical subspecialty. The diseases we grapple with are often severe, the rare complications we will invariably encounter may be unforgiving, and the demands of practicing retina in these uncertain and changing times are considerable. All of this can profoundly affect our staff, families, and us—not merely as it pertains to being a physician, but at the core of what it means to be human.

THE FIRST 5 YEARS: BEYOND THE CLINICAL HURDLES

About the Column

Moving forward, in this new corner of *New Retina MD* we will examine some of the challenges that arise in the first few years of practice, beyond the clinical and medical aspects. In this regard, I hope that it can serve to help us reflect upon ways in which we can become better retinal physicians. ■

Allen Chiang, MD, is an attending surgeon on the Wills Eye Retina Hospital Service, a physician with Mid Atlantic Retina, and on the clinical faculty at Thomas Jefferson University in Philadelphia. Dr. Chiang may be reached at +1-800-331-6634 or at achiang@midatlanticretina.com