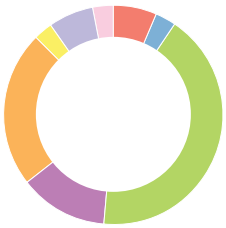
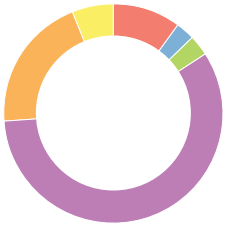
The results* of the last survey

1. A referral is triaged as requiring a **routine** appointment. What is an acceptable time to wait before any harm occurring while waiting becomes a breach of duty?



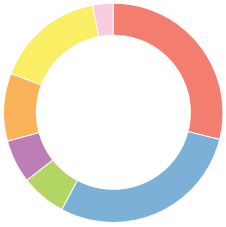
6.5%	1 month	23%	6 months
3%	2 months	3%	9 months
42%	3 months	6.5%	1 year
13%	4 months	3%	18 months

2. A referral is triaged as requiring a **soon** appointment. What is an acceptable time to wait before any harm occurring while waiting becomes a breach of duty?



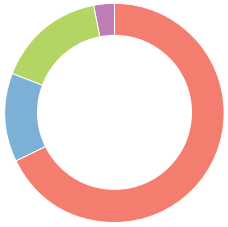
10%	1 week	20%	2 months
3%	2 weeks	6%	3 months
3%	3 weeks	0%	4 months
58%	1 month	0%	6 months

3. A referral is triaged as requiring an **urgent** appointment. What is an acceptable time to wait before any harm occurring while waiting becomes a breach of duty?



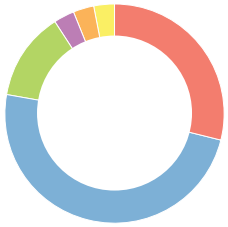
29%	24 hours	10%	1 week
29%	48 hours	16%	2 weeks
6.5%	72 hours	0%	3 weeks
6.5%	5 days	3%	1 month

4. When faced with a patient with suspected postoperative endophthalmitis (hypopyon, redness, pain and reduced vision), what is an acceptable delay to first injection of antibiotics?



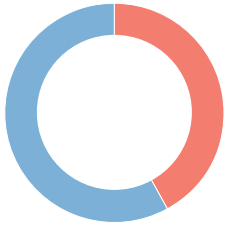
68%	3 hours	3%	24 hours
13%	4 hours	0%	48 hours
16%	6 hours		

5. In a patient with a macula-on retinal detachment approaching the arcade and a superotemporal retinal tear, how long is it acceptable to wait for surgery?



29%	12 hours	3%	7 Days
49%	24 hours	0%	14 Days
13%	48 hours	0%	21 Days
3%	72 hours	0%	28 Days
3%	5 Days		

6. If a patient with a macula on detachment and 6/6 vision develops a macula off detachment while waiting for surgery, is it a breach of duty?



42%	Yes
58%	No

*Please be aware that this data does not form part of a peer reviewed research study. The information therein should not be relied upon for clinical purposes but instead used as a guide for clinical practice and reflection. The sample size for the December 2024 survey was: 31 respondents.

In order to litigate and receive an award by the Court, the Claimant is required to demonstrate harm. Harm can occur due to many causes and the most heartbreaking of those which I see are the avoidable ones and the ones that repeat time and time again.

We are aware of the delays to follow-ups and the massive capacity demands we are all facing. I contemplated putting the figures into this article regarding delays to clinic appointments however it was too depressing. I do not think any of us need reminding of the issues we face. We were stretched before Covid-19 and ever since we have been under even more pressure. Despite our efforts to work smarter, do extra clinics, utilise the independent sector and other providers, we are still struggling.

Particularly during the Covid-19 pandemic, we did our best to risk assess our patients and triage them. The very nature of ophthalmology means that patients can deteriorate significantly without realising it. Glaucoma is the obvious example. We therefore cannot rely on patients' symptoms, as opposed to, for example, orthopaedic doctors who could advise their patients to make contact if their knee starts hurting again.

Inevitably, the triage and risk assessment process will help protect populations of patients but will never fully protect individual patients. Out of, for example, 1000 low-risk patients, one or two will suffer harm from undue delay to follow-up. By definition, they are low risk and not low risk. It is not yet clear whether the Courts will give us a 'get out of jail free' card when it comes to whether we can use the Covid-19 pandemic as a reasonable excuse for delays.

I am often asked when a delay to follow-up or delay to surgery becomes a breach of duty. It is a hard question to answer. Any perceived delays obviously depend on many factors, including the number of consultants working in a department, how many lists there are, how many patients are operated upon per list, or even whether one of the consultants is off on long-term sickness. Capacity is not infinite and some patients will have to wait for operations and wait for follow-ups. Harm is almost inevitable to some of these patients sadly.

When asked about delays to first appointment after referrals to the hospital, I try and be pragmatic and not be too prescriptive. An urgent appointment can be for many different conditions and often what an optometrist may consider urgent is not what we, as ophthalmologists, would deem to be urgent. The same can be said for routine and soon appointments. There is no real guidance or benchmarking as to what these referral urgencies mean.

When asked when a patient with a 'routine' appointment request needs to be seen before it becomes a breach of duty, there was a significant variance of opinion. More than half of you felt that a patient waiting beyond three months for a routine appointment who then comes to harm has been subject to a breach of duty, whereas almost a quarter of you felt that a six-month wait was reasonable.

When asked the same question about a 'soon' appointment there was again significant variance. Almost three quarters of you felt that any delay beyond one month was unreasonable and effectively an undue delay / breach of duty. Ten percent of you felt that anyone waiting more than a week would have an argument that they suffered negligence, if they came to harm – I think, considering the problems we face with capacity, that is excessively harsh.

When asked the same question regarding what an 'urgent' appointment should mean, unsurprisingly (I have ceased to be surprised by the variance of opinion in our learned exclusive group) there was more of a consistent result with almost two thirds of you suggesting less than 48 hours, although some felt longer, was reasonable.

We also have to consider where to slot those 'urgent' patients in. I usually assess the condition and give lee-way of up to a week to be seen, with obvious exclusions such as giant cell arteritis for example. The vast majority of you would agree however, it is notable that 16%

of you feel that such patients need to be seen within three days and more than half have set five days as the cutoff point.

I have seen many cases of patients who have sadly developed infective endophthalmitis after cataract surgery. With more and more of these being done in the independent sector, the management of this devastating complication has become the source of some litigation. The typical case is that a patient presents back to an independent provider and they are suspected of having endophthalmitis. There is then a delay to their assessment by the acute trust and their first injection. The eye is lost and the question is raised as to whether the delay to intravitreal injections was contributary to the visual loss.

Infective endophthalmitis is an ocular emergency and the time to first intravitreal injection of antibiotics is, in my opinion, key. More than three quarters of you felt that any delay of more than four hours was unacceptable and I agree. This is an emergency and they need to be injected ASAP. There is a subsequent question of causation as we all know that the prognosis is poor anyway. Would earlier injection actually have spared vision? When I am asked about this, I try and stratify the patient dependent on their presenting vision and the organism grown to try and give a reasonable opinion as to whether earlier treatment would have spared some vision or spared the eye itself. This topic is something I am acutely aware of personally, having had the first endophthalmitis of my entire career of probably more than 15,000 phacos. The next survey will focus on this issue further.

Another common source of litigation is delay to retinal detachment repair. We all know that as soon as the macula detaches there is a step-wise deterioration in visual prognosis. So, getting in and repairing the retinal detachment before the macula detaches is key. The macula is threatened in the patient described in question 5. Around a quarter of you felt that the repair should be done within 12 hours, while around three-quarters of you felt that it had to be repaired within 24 hours. Certainly, if my mother had such a macula on detachment and she was left over the weekend without an operation and subsequently the macula detached and she ended up 6/24, I would be asking why surgery was not done sooner.

Question 6 follows on from this and asks you if a patient's retinal detachment progressed to macula-off while waiting for surgery, would there be a breach of duty? The split was almost 50:50 however the 'no' responders won out. This response seems to contradict the responses to the previous question where you all in your minds had a certain time which is acceptable to wait for surgery. If a patient waited longer than the cut-off point you have in your head, then surely that would represent a breach of duty?

None of these are simple questions and often I find myself feeling guilty about asserting that a patient waiting suffered a breach of duty due to a delay when I know very well that the poor hospital services are struggling and cannot provide appointments which simply are not there. Are we flogging the poor Trusts, and the poor NHS too, with financial penalties via their indemnity schemes, when they simply do not have the capacity to meet the demands we expect of them?

SECTION EDITOR

Amar Alwitry, FRCOphth MMedLaw,
Consultant Ophthalmologist, Leicestershire and Nottingham, UK.
amar.alwitry@nhs.net

Our next survey

1. Where do you think the organisms come from which cause post-phaco endopthhalmitis?
   - ❑ From the ocular surface during the procedure
   - ❑ Due to contamination of the surgical instruments
   - ❑ From the theatre environment
   - ❑ From the ocular surface through the cornea sections in the postoperative period due to patient factors (rubbing eyes, touching eye with drop bottle)
   - ❑ From the ocular surface through the cornea sections in the postoperative period due to fish-mouthing or insecurity of the corneal sections
   - ❑ Endogenous
2. Should the independent sector manage their own cases of endophthalmitis?
   - ❑ Yes ❑ No
3. When faced with a patient who is four days after cataract surgery with increasing pain and photophobia with cells in the anterior chamber and the anterior vitreous but no hypopyon, how would you manage it?
   - ❑ Intravitreal sample and injection of antibiotic
   - ❑ Admit for intensive steroids and observation
   - ❑ Increased steroid drops and observation next day
   - ❑ Increased steroid drops and observation in one week
4. Do you use intracameral cefuroxime at the end of your cataract procedure?
   - ❑ Yes
   - ❑ No, but I give a different intracameral antibiotic
   - ❑ No, I use subconjunctival antibiotics
   - ❑ No
5. A patient develops infective endophthalmitis and loses their eye. It transpires that intracameral cefuroxime was not used at the end of the procedure and instead a subconjunctival injection of antibiotic was given. Is there a breach of duty?
   - ❑ Yes ❑ No
6. If you were having cataract surgery, would you insist upon an intracameral injection of cefuroxime at the end of your procedure?
   - ❑ Yes ❑ No
7. In a patient with a penicillin allergy having cataract surgery, would you give intracameral cefuroxime at the end of the procedure?
   - ❑ Yes ❑ No
8. In a patient with penicillin anaphylaxis having cataract surgery, would you give intracameral cefuroxime at the end of the procedure?
   - ❑ Yes ❑ No
9. I routinely give a drop of preservative-free chloramphenicol at the end of my procedure as well as intracameral cefuroxime. I have no evidence base for this practice. Up until this month I have never had an infection in my 15,000+ cases (an endophthalmitis rate of 0.00007%). Should I stop doing it?
   - ❑ No, if it isn't broken don't try to fix it
   - ❑ Yes, you have no evidence for the practice
   - ❑ Yes, you have no evidence for the practice and you may be contributing to bacterial resistance

Complete the next survey online here:
www.eyenews.uk.com/survey
Deadline 1 March 2025