Letter to Editor

Legal Issues in Ophthalmic Anaesthesia

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Dear Sir/Madam,

A large number of people suffer from disorders of the eye. Some can be treated medically but others require surgery. The motto of eye surgery is "so that all may see". Many surgeries can be performed under local anaesthesia (LA) but a significant number need general anaesthesia (GA).

It is a well-known fact that anaesthesia is not one hundred per cent safe. Complications can occur even during minor procedures in healthy individuals because of human error, equipment failure and other factors. Expected and accepted mortility in eye surgery is negligible. Also, there is lesser degree of awareness among patients and the attendant regarding the systemic risks involved in patients undergoing eye surgery under GA/LA. Hence, it is essential for an ophthalmic anesthesiologist to know basically, how to practice and to provide a safe anaesthesia for their patients.

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During preoperative assessment, it is important and mandatory to determine whether the patient is taking any blood thinner medications or herbal drugs like gingko biloba. If the patient is already on anticoagulant medication, then with the concurrence of the treating physician, it can be withheld accordingly, until the effect wears off.

On the operating table, patient has to be positioned at a comfortable working distance and in a supine posture with good overhead illumination. Before infiltration, corneal protectors in the form of a corneal conformer or a spatula must be used, Figure 1. The needle hub must be securely fastened to a dry syringe tip, maximizing the friction force holding the needle in place. Alternatively, a Luer-lock syringe can be used. 1.5-inch, 27-gauge needle allows for long passes beneath the skin, decreasing the number of times the tissues are entered, thus causing less pain and bruising. A 0.5- inch, 30-gauge needle can be substituted for smaller areas of infiltration. Needleless jet injection devices are not advised to be used because posterior segment trauma has been reported.[4] Bending the needle at 30 degrees from the hub is another good practice reported by some authors which can reduce the complications.[5]

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1. If there is any significant possibility of a complication under GA, the surgery should be performed under LA with monitored anaesthesia care. There is no life-saving surgery in ophthalmology, only eye saving surgeries. Hence, it is important to remember not risk life in order to save eyes even if the patient gives consent.
2. Communication between anaesthesiologist, patient, his relatives and ophthalmologist is of utmost importance. When a decision regarding surgery is made by the ophthalmologist, the pros and cons of general and local anaesthesia should be discussed with the patient, his relatives and the ophthalmologist.
3. A thorough pre-anaesthetic evaluation is mandatory before a final decision regarding GA is made. Medical history, physical examination and investiations will guide us in decision making. Wherever indicated, an opinion from a physician, cardiologist, neurologist or any other specialist should be obtained.
4. Conduct of anaesthesia: Equipment check, induction, maintenance and recovery have to be carefully done as per accepted standards. Indian society of Anaesthesiologist and World Federation of Society of Anaesthesiologist guide lines provide that a qualified anaeshtesiologist should continuously attend to any patient under GA. Hence, leaving a patient under GA unattended for whatever reason is not acceptable at all. From induction to recovery, the anaesthesiologist has to remain with the patient.
5. Documentation: Right from preanaesthetic evaluation till recovery from anaesthesia, everything should be properly documented. It is recommended that vital parameters of the patient under GA be recorded every five minutes. Longer gaps between recording parameters gives an impression that anaesthesiologist was not with the patient during that period. Same applies to attending to two patients under GA simultaneously.

In spite of taking all these precautions, one cannot rule out the possiblity of litigation on grounds of medical negligence.

Let us go through a coupleof court judgments so that we can learn to avoid those mistakes that others have made.

1. Asha Devi & ors v Dr. Sanjay Lal Das & Anr. National Consumer Dispute Redressal Commission: Anaesthesia administered by unqualified doctors not possessing Diploma or Degree in Anaesthesiology. It must be noted that any amount of experience cannot substitute for qualification. Not only one should hold a qualification, but it must be registered with the Medical Council. And not only should it be registered but registration has to be renewed periodically as per the rules of the Medical Council. If the qualification is not registered or registration is not renewed, one is not legally authorised to practice.
2. The Medical Director...V Dr. Meenakshidhar. Amrita Institute of Medical Sciences, Ernakulum. (National Consumer dispute Redressal Commission)

Death during squint surgery: A nine-year-old child died during a squint correction surgery under GA. A medical inquiry commission gave the expert opinion that there was no negligenceon the part of doctors. But the court (National Consumer dispute Redressal commission) made the following observations:

It was claimed that Glycopyrrolate was administered to counteract the bradycardia. However, the drug entered in the anaesthesia record was "Glyco". Court observed the "Glyco" cannot be taken as "glycopyrrolate". "Glyco" can mean many things. Hence it observed that Glycopyrrolate was not administered. Therefore, we must use only standard abbreviations in our record or write the full name of the drug administered.

Court observed that proper informed consent was not obtained from the parents of the patient. Consent taken from the mother looks ritualistic. Therefore, an individualised informed consent must be obtained.

It was claimed that a retro-bulbar block was given preoperatively to prevent cardiac arrest. The anaesthesiologist mentioned that the block was administered by the surgeon. However, neither anaesthesia record nor the surgeon's operation notes had any mention of the retro-bulbar block. Hence court concluded that retro-bulbar block was not given.

Therefore, whatever is done should be recorded in the anaesthesia notes. Whatever is not recorded is taken as not done by the courts.

There was no record of a pre-anaesthetic evaluation. It was mentioned that "routine premedication" was given. Court observed that unless specific drugs are mentioned, "routine premedication" can mean anything. Therefore, the court concluded that the medical record was not made properly.

Looking at the above examples tells us that we can never be too careful. Even if you have done thousands of cases successfully, a single case of medical negligence can mar your reputation and confidence. The most neglected aspect of our anaesthetic management is the anaesthesia record. In medico-legal cases, this is the one that can make or break you.

It cannot be emphasized enough that every anaesthesiologist must have sufficient professional indemnity insurance and must keep his medical license renewed and valid.

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There are no conflicts of interest.