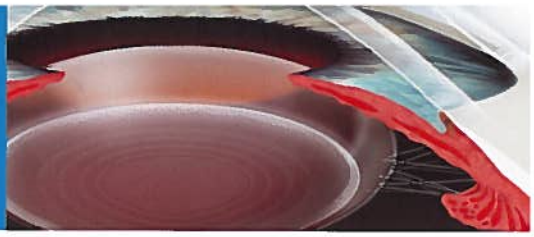
Risk Management Hotline



Reduce Your Risk of a Refractive Surgery Claim

By Anne M. Menke, RN, PhD
OMIC Risk Manager

The refractive surgery claims study featured in this *Digest* points to actions ophthalmologists can take to improve the safety of these procedures and reduce the likelihood of a malpractice claim. Document any actions you take in the patient's medical record.

Q OMIC's refractive surgery underwriting requirements state that the "*surgeon* must perform and document an independent evaluation of the patient's eligibility for surgery, including performing a slit lamp exam and reviewing topography, pachymetry, pupil size, and discuss monovision option for presbyopic patients" and "*personally* obtain informed consent." Is OMIC opposed to comanagement?

A No, but we have learned from our claims experience that comanaged care has risks that must be reduced. Experts for the plaintiff regularly scrutinize how much care is delegated to non-ophthalmologists, whether such delegated care is properly supervised, and if the patient freely consented to the arrangement. We recommend that you develop and implement written protocols for comanagement (see "Comanagement of Ophthalmic Patients" at www.omic.com). Clarify in the protocol the role of the surgeon in preoperative and postoperative care and consent. Release the patient to the care of the non-surgeon only when deemed stable, and especially continue to see the patient if there have been complications. Request that comanagers send you reports on all visits, and review, date, and sign the reports before they are filed in the medical record.

OMIC's position on the role of the surgeon reflects that of the American Academy of Ophthalmology (AAO) and the American Society of Cataract and Refractive Surgery (ASCRS). In joint clinical statements, these organizations have clarified that the "ultimate responsibility for obtaining accurate preoperative assessment and the patient's informed consent to refractive surgery rests with the ophthalmologist who performs the surgery."[1] Referencing case law, Medicare regulations, actions by the Office of the Inspector General, and ethical standards, their analysis notes that the law imposes duties on surgeons who do not provide the postoperative care. Ophthalmologists who do not meet this obligation could be accused of patient abandonment and risk "liability for patient injury, including injury resulting from the acts or omissions of others to whom the provision of postoperative care is inappropriately delegated, or for inadequate patient informed consent, or both."[2]

Q What has OMIC learned that can help me improve the quality of my preoperative care?

A Patients who present to ophthalmologists have often already decided that they want refractive surgery, and know that they have myopia, hyperopia, and astigmatism, the conditions refractive surgery is designed to treat. Rather than focusing on indications for surgery, therefore, the preoperative assessment aims to ensure that the patient is a good candidate and to fully advise him or her of the expected risks, benefits, and alternatives. First, avoid if possible meeting the patient for the first time on the day of surgery. If you cannot avoid this, obtain and review the patient's medical record, especially the topography, before the day of surgery. Send the patient a copy of the consent form to review, and ensure that the consent is not signed until after you conduct the informed consent discussion.

During the preoperative evaluation, rule out ocular and medical contraindications to refractive surgery, initially and before each retreatment. In particular, ensure that there are no topographical or clinical signs of forme fruste keratoconus or ectasia. Assess and disclose the impact of ocular and/or medical comorbidities that are not absolute contraindications but that may influence the visual outcome (e.g., glaucoma, diabetes, stable autoimmune disease, dry eyes). Verify refractive stability and the cause of decreased visual acuity (i.e., regression vs. ectasia), especially before performing repeat surgery. Ask the patient to help identify work and leisure activities that could be impacted by the refractive outcome, such as night driving, piloting a plane, working as an accountant, and knitting. Consider providing the patient with the new AAO guide "Is LASIK for Me?" available at www.aao.org. Ascertain the patient's goal for surgery and ability to handle disappointment ("How will you feel if you still need to wear glasses at work after surgery?").

Q What actions should I consider at the surgery center?

A Verify that equipment is regularly maintained, and check for proper functioning of equipment before procedures. Implement the recommendations of the AAO Prevention of Medical Error Task Force so that the correct patient, procedure, eye, and laser settings are assured. If there is a flap complication, refund the patient's fees and stay in regular phone contact while the cornea heals.

1. AAO/ASCRS Clinical Statement. "Appropriate Management of the Refractive Surgery Patient" (Issued August 2004, Revised January 2008). Available at www.aao.org.

2. AAO/ASCRS Clinical Statement. "Ophthalmic Postoperative Care (OPC)" February 2000. Available at www.aao.org.