

# OMIC DIGEST

## Lawsuits Related to Preoperative Evaluations

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

**W**hen plaintiffs sue for medical malpractice after eye surgery, experts review the entire process of care from diagnosis of the condition to management of postoperative problems. Sometimes, claims that initially appear to be about the outcome of a surgical procedure ultimately hinge on care provided well before the surgery. This issue of the *Digest* will examine allegations of negligent preoperative evaluation, specifically, medical preoperative decision-making.

Surgery and anesthesia induce a stress response that can cause cardiovascular and respiratory complications during and after surgery and exacerbate preexisting medical conditions such as heart disease and renal failure. Therefore, it is customary for patients to be screened and treated,

whenever possible, for conditions that increase their risk for surgery. Lawsuits related to medical decision-making prior to surgery focus on the quality of the preoperative history and physical examination (H&P), the effectiveness of treatment of medical conditions to optimize the patient's condition, and the adequacy of the informed consent discussion. These claims arise against ophthalmologists, primary care physicians, medical specialists such as cardiologists and hematologists, and anesthesia providers.

### Preop history and physical exam

A number of lawsuits filed by patients who suffered serious medical problems in the perioperative period allege that the preoperative H&P was inadequate and raise questions about who may perform the exam, as the following case study shows.

A 41-year-old female patient with proliferative diabetic retinopathy needed vitrectomy surgery to repair a superior tractional retinal detachment. In addition to diabetes, the patient reported a history of hypertension and renal insufficiency, so the ophthalmologist asked the patient's primary care physician to evaluate her for surgery. The patient had been hospitalized one week prior to surgery for uncontrolled diabetes and renal insufficiency. The PCP felt that additional tests were not necessary and that the patient could undergo surgery with an anesthesiologist providing general anesthesia. Soon after induction, the patient developed bradycardia. It responded to treatment, so the surgery resumed. When the patient developed a second episode of bradycardia 20 minutes later, the anesthesiologist asked the surgeon to stop the procedure. The patient was unresponsive in the post-anesthesia care unit and never regained consciousness. Diagnosed with anoxic brain injury, she died three months later. The ophthalmologist, PCP, and anesthesia provider were all sued. Defense experts for the ophthalmologist supported the

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### Message from the Chair

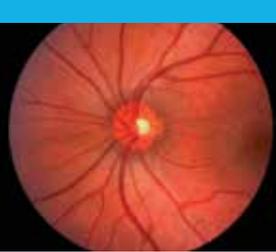
Like all of you, I spent the weeks leading up to April 15th gathering receipts, calculating capital gains, and resigning myself to Ben Franklin's astute and timeless 1789 observation, "...[I]n this world nothing can be said to be certain, except death and taxes." At the risk of offending one of our Founding Fathers, to this short list of life's inevitabilities, I'd suggest we add "Change." Look around you. Blockbuster to Netflix, empty nest to

a boomerang young adult in your basement, Jay to Jimmy on late night TV—if you can't embrace change, you can't embrace life.

Change is also in the air here at OMIC. What a delight to be stepping into the shoes of my oculoplastic's colleague and mentor, John Shore, as I assume leadership of the Board for the next two years. Dr. Shore has handed me the reins of a company enjoying unparalleled success in the medical malpractice marketplace. Of all U.S. ophthalmologists who can choose their malpractice carrier, nearly half choose OMIC. How have we become the undisputed leader in ophthalmic risk management and claims

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# Eye on OMIC



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## Denise Chamblee is New Risk Management Chair

**T**he OMIC Risk Management Department welcomed a new committee chair and risk management specialist earlier this year. Denise R. Chamblee, MD, a pediatric ophthalmologist in Newport News, VA, and an OMIC Board member, will chair OMIC's Risk Management Committee. Since joining the Committee in 2008, Dr. Chamblee has been a major contributor to the development of OMIC's retinopathy of prematurity hospital and office safety nets. She also works closely with the American Academy for Pediatric Ophthalmology and Strabismus on ROP-related patient safety/quality of care issues. Dr. Chamblee is a graduate of the American Academy of Ophthalmology's 2013 Leadership Development Program.

Michelle Pineda joined the OMIC staff as a risk management specialist in February. Ms. Pineda has a Masters of Business Administration from St. Mary's College in Moraga, CA, and brings years of work experience with a large medical professional liability carrier and Bay Area high tech companies. She will work with Anne Menke, RN, PhD, and Hans Bruhn, MHS, to handle confidential hotline calls and other risk management queries from insureds.

The Risk Management Department also has a new fax number, 415.771.1095, for all risk management-related business. The department's phone number is still 800.562.6642, option 4. Risk management queries can also be emailed to [riskmanagement@omic.com](mailto:riskmanagement@omic.com).

### Message from the Chair

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adjudication? Teamwork and the deep bench composed of our San Francisco-based loyal staff of 45 captained by President and Chief Executive Officer Tim Padovese; the dedicated and insightful ophthalmologist Board and Committee members, past and present; collaborative engagement of our sponsor, the American Academy of Ophthalmology; and most importantly the faith, feedback, and trust of you, our insured physician owners.

I became an OMIC insured 16 years ago when, fresh out of fellowship and without getting competitive quotes or considering other companies, I staked my professional liability with OMIC based on no more than brand recognition and the endorsement of the Academy. This could have been a potentially poor business decision (I mean, who doesn't bid out one of the largest expenses for a doctor just starting out in practice?). But it ended up being one of the greatest professional choices I ever made.

While these are exceptional times for our company, I recall the growing pains we had during my first few Board meetings in the early 2000s. It was a tense time for medical professional liability insurers; many exited what had become an increasingly unprofitable marketplace while others simply became

insolvent. Displaced ophthalmologists looking for a safe haven found one with OMIC. We were a smaller company then and absorbing these displaced doctors put considerable pressure on our performance measures. Our seasoned executives, financial advisors, and physician Board members made calculated and at times difficult decisions that allowed us not only to grow our insured count but maintain and improve our fiscal health as well. A.M. Best rewarded OMIC's sound decision making by upgrading our financial stability rating to "A" (Excellent) in 2007, a rating we have maintained every year since then.

Ophthalmologists who placed their professional liability faith in OMIC are being rewarded for their loyalty. In 2014, OMIC is providing a 25% dividend for all active policyholders. Upon application of this dividend, OMIC will have returned more than \$30 million to policyholders over the past five years. While you can always count on OMIC's prudent corporate governance, there will undoubtedly come a time in this inherently cyclical business when we will again face headwinds. As your new Chair, I promise you that, with OMIC, you are in the best hands to weather whatever change or challenge lies ahead. Now, if only OMIC could help decipher the U.S. tax code.

**Tamara R. Fountain, MD, Chair of the Board**



## When Claims Aren't Covered

Kimberly Wynkoop, OMIC Legal Counsel

Receiving notice of a claim or being served with a lawsuit can be a very stressful and upsetting experience. It is hard not to take it personally. It is imperative that insureds feel confident that their insurance company will be there for them when they need it most. Sometimes, however, claims will not meet the company's requirements for coverage. This article addresses some of those circumstances and explains what OMIC will do.

Because OMIC is owned and directed by its insured ophthalmologists, we take our responsibility to them very seriously. It is only after careful review and consideration that OMIC issues reservations of rights or denials of coverage. We wish that we never had to send such letters to our insureds, but sometimes it is necessary in order to protect all of our policyholders from inappropriately bearing the costs of claims that fall outside the terms of the policy.

OMIC is legally required to send an insured a "reservation of rights" if there is a possibility that the policy covers some but not all of the allegations or demands in a claim or lawsuit. In such cases, OMIC assigns counsel and defends the claim. OMIC is simply reserving its right not to pay money to the claimant for uncovered activities, allegations, or damages.

Some of the most common reasons OMIC reserves its rights include:

- The plaintiff is seeking punitive damages. Most medical professional liability policies do not cover punitive or other exemplary damages. In fact, in many jurisdictions such damages are not insurable. OMIC's policy does not cover these damages, but our defense attorneys are usually successful in getting demands for punitive damages dropped.

- The plaintiff alleges intentional acts, such as willful and wanton conduct, fraud, or false advertising. For obvious moral hazards, it is against many states' public policy to insure for intentional acts. Intentional acts are often alleged so that the plaintiff can seek punitive damages. Again, these claims are rarely successful and OMIC will usually have such allegations removed from the complaint during litigation.

- Other allegations for which OMIC provides a conditional defense but no payment of damages are criminal acts, sexual misconduct, acts or omissions caused by the insured's substance abuse, guaranteed results, and vicarious liability due to an apparent partnership.

OMIC's appointed defense counsel will defend insureds against all allegations, not just those covered by the policy. Counsel will work diligently to have uncovered allegations or damages removed from the complaint, whenever appropriate, so insureds will not be left with uninsured losses, should the plaintiff prevail.

If you receive a reservation of rights letter, don't be alarmed. Your claims representative should have already discussed with you that OMIC will be reserving its rights and that a letter outlining the issues will be forthcoming. Therefore, such a letter will rarely come as a surprise. If you have questions about your coverage, please call us. Your OMIC defense attorney will do his or her best to protect your interests. Continuing to work closely with your OMIC defense team will give you the best chance of obtaining a swift and satisfactory resolution to the claim or lawsuit.

Rarely, claims or lawsuits are reported that are not covered under the policy. In such a case, OMIC, following communication from your

claims representative, will send you a letter to explain the reasons.

Some of the most common reasons a claim is not covered are as follows:

- The person or entity who the claim is made against is not insured with OMIC. This means that the person named as the defendant is not listed on the Declarations of your policy, or is not an unnamed non-physician employee (except ODs and CRNAs) of a person or entity listed on the Declarations. It is likely that the person sued will have a policy with another carrier, which should cover the claim.

- The basis of the claim is not covered by the policy. The OMIC policy has five Coverage Agreements, covering such activities as direct patient treatment, professional committee activities, and premises maintenance. If the lawsuit is based on your alleged breach of an employment contract, for example, the claim will not be covered. You or your practice may carry insurance for non-professional liability claims, such as general liability, employment practices liability, or directors and officers liability insurance. You should alert such other carriers of the claim.

- The allegations are excluded by the policy. The Coverage Agreements and General Exclusions provide a list of allegations that the policy does not cover. For example, the performance of various specific procedures, such as micropigmentation of the breast or placement of arch bars on the teeth, are excluded. Wrongful acts, such as intentional invasion of privacy, discrimination, and harassment are also excluded. Insureds should be aware of the policy exclusions and conduct their practices such that uncovered activities are not undertaken or insurance for such activities is provided elsewhere.

# Lawsuits Related to Preoperative Evaluations

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physician's care, opining that he had correctly asked the patient's PCP to determine the safety of the planned surgery and anesthesia and had no role in the anesthesia care. The PCP was similarly supported by his defense experts. Both plaintiff and defense experts, however, criticized the anesthesiologist, indicating that he had not adequately addressed the preoperative anemia from renal insufficiency, which predisposed the patient to hypoxia, and did not properly manage the bradycardia and hypoxia when they developed. Both the eye MD and PCP were dismissed from the lawsuit, while the anesthesiologist settled for a confidential amount. The outcome of this claim is consistent with other lawsuits related to anesthesia complications: while the ophthalmologist's care will be carefully scrutinized, eye surgeons are generally not held liable for the care of anesthesiologists and Certified Registered Nurse Anesthetists.

## Is a consultation needed?

The ophthalmologist in the previous case recognized that the patient had significant medical comorbidities and appropriately asked the patient's PCP to evaluate her readiness for surgery. While the consultation did not prevent a lawsuit, it did help get him dismissed from the claim. In contrast, the eye surgeon in the case presented in the *Closed Claim Study* on page 6 was aware that the patient was on dual-therapy anticoagulation but did not seek input from the physician who had prescribed the medications. The defendant ophthalmologist had performed vitrectomy surgery without incident on many other patients on anticoagulants, so he did not anticipate problems with this one. This claim raises important questions. May an ophthalmologist perform the preoperative evaluation? If so, what are the patient safety and liability risks? And, prior to surgery, is the

ophthalmologist required to consult with the physician who prescribed anticoagulants?

As a general rule, physicians may use any and all means to diagnose and treat a patient. Accordingly, performing a preoperative history and physical exam is certainly within the scope of practice of an ophthalmologist, and OMIC's professional liability policy provides coverage for this exposure (see the *Hotline* article on page 7 for more advice on conducting and delegating these exams). Malpractice lawsuits related to preoperative evaluations will center not on the ophthalmologist's scope of practice, but rather on the standard of care and whether the ophthalmologist adequately assessed the patient's medical condition.

Revised recommendations from the American College of Cardiology/American Heart Association (hereafter referred to as the "Guidelines"), and a revised Practice Advisory for Preanesthesia Evaluation from the American Society of Anesthesiology (hereafter referred to as the "Practice Advisory") provide valuable input on the purpose and scope of the preoperative evaluation and on anticoagulants. Explicitly acknowledging that surgery and anesthesia pose risks for all patients, these documents clarify that physicians no longer provide "medical clearance" for surgery. Rather, their evaluation produces a risk profile—low, medium, or high—and recommendations on perioperative management that guide the entire treatment team. The risk assessment is based on both the type and invasiveness of the surgical procedure and the patient's medical condition. The Guidelines clarify that in terms of procedural risk "...superficial and ophthalmologic procedures represent the lowest risk and are rarely associated with excess morbidity and mortality." For most eye surgeries, therefore, the goal of the preoperative evaluation is to assess the perioperative

risk posed by medical comorbidities. The Guidelines and Practice Advisory help clarify that these assessments have a limited purpose and scope. They are not intended to diagnose and treat all medical conditions, but rather to screen for conditions that need to be treated before or during surgery. The Guidelines acknowledge that these assessments are conducted by a variety of providers, including surgeons, and that a formal consultation may not be necessary if "sufficient information about the patient's cardiovascular status is available, symptoms are stable, and further evaluation will not affect preoperative management." The important question to ask then is when do ophthalmologists need input from PCPs and medical specialists in order to safely plan the surgery.

## Anticoagulants

This issue's *Closed Claim Study* raises this question in terms of anticoagulants. The Guidelines discuss antiplatelet therapy but not treatment with warfarin. They acknowledge that dual antiplatelet therapy with aspirin and clopidogrel does increase the patient's risk of bleeding compared to aspirin alone. They clarify, however, that procedures with a low risk of bleeding may proceed despite dual therapy and that monotherapy with aspirin need not be discontinued prior to elective noncardiac surgery, for while the frequency of bleeding rises, the severity of the increased bleeding and mortality from it are not usually greater. The Practice Advisory includes an acknowledgement that anticoagulant medications and alternative therapies pose additional risk but does not make specific recommendations about them.

OMIC has handled a number of claims involving either hemorrhage and vision loss while the patient was anticoagulated, or heart attack and stroke when anticoagulants were discontinued. Expert testimony has varied considerably, depending upon the type of surgery, anesthesia,



anticoagulants, and medical comorbidities. Similarly, discussions with OMIC consultants from many subspecialties about preoperative evaluations in preparation for this article revealed a wide range in how ophthalmologists conduct these assessments.

There is some agreement, however, on anticoagulants. Experts and consultants concur that it is important for the ophthalmologist to explore with the patient the reason anticoagulant medication has been prescribed and the relative risk of hemorrhage associated with the specific surgery. For some types of eye surgery, ophthalmologists consider the consequences of a thrombotic event to be a greater risk than the potential vision loss from hemorrhage and do not discontinue anticoagulants prior to most cataract or retinal procedures. If the preoperative evaluation indicates that the patient is at low risk and no changes to the current medical treatment are needed, the ophthalmologist may reasonably conclude that consultation with the PCP or medical specialist is not required. If anticoagulants will be continued, the ophthalmologist may need to change the surgical technique or choose an anesthesia with a lower risk of hemorrhage (e.g., topical or sub-Tenons instead of retrobulbar), as well as monitor conditions such as hypertension that increase the risk of hemorrhage.

Other types of eye surgery have a greater risk of hemorrhage, including corneal transplantation and glaucoma surgeries as well as eyelid and orbital procedures. Oculofacial plastic surgeons, for example, may elect to postpone elective surgery unless anticoagulants have been stopped. In this instance, since the ophthalmologist judges that the patient's current medical treatment needs to be changed, he or she would be well-advised to consult with the physician who prescribed the

medication for advice on whether the medication may be safely stopped and recommendations on how to stop and restart it. If the patient has self-prescribed aspirin or supplements that impact the clotting cascade, the ophthalmologist may, of course, advise the patient to stop taking the aspirin and supplements before procedures that pose a risk of hemorrhage.

### Preoperative testing

While there is some agreement on when to continue and stop anticoagulants, there is no clear consensus on the need for preoperative coagulation studies. Both the Guidelines and the Practice Advisory stress that routine preoperative tests are never indicated, with routine defined as a test ordered in the absence of a specific clinical indication or purpose. Rather, the Guidelines recommend only ordering tests if the result is likely to influence patient treatment, such as a change in the surgical procedure performed, medical management or monitoring during the perioperative period, or postponement of surgery until the medical condition can be stabilized. This position is consistent with the results of research conducted by the Agency for Healthcare Policy and Research and summarized in a statement from the American Academy of Ophthalmology's (AAO's) Quality of Care Secretariat, which showed no decrease in complications related to cataract surgery for patients who underwent routine preoperative tests. Standards of practice for anticoagulation in the perioperative period continue to evolve. One approach adopted by some eye surgery centers to assess the risk of hemorrhage in patients on warfarin is to test the INR on the day of surgery. Written policies indicate when the decision to proceed with surgery needs to be revisited by the surgeon and anesthesiologist. Ophthalmologists may want to query anesthesia and

primary care colleagues for input on what clotting studies, if any, should be done prior to eye surgery.

### Risk reduction strategies

Ophthalmologists who determine a consultation with the patient's PCP is indicated need to inform the PCP of the intended procedure, its risk of hemorrhage, and type of anesthesia, and document all discussions. As part of the informed consent discussion with the patient, the surgeon should address the risks and benefits of whatever decision is made about anticoagulant use and carefully document the decision-making process, discussion, and plan. Policyholders may find it helpful to use a consent form with preoperative instructions for anticoagulants (go to [www.omic.com](http://www.omic.com)). The patient and surgical team need to be alerted to the decision and symptoms of embolic events or hemorrhage. Patients should be given clear, written instructions on how to manage anticoagulants, including stopping and restarting information if they are discontinued. Confirming that the patient has followed these instructions is an important safety step addressed in the ophthalmic-specific surgical checklist OMIC has developed in collaboration with the AAO and other organizations.

Malpractice claims related to preoperative evaluation occur regularly. Ophthalmologists may help prevent these claims by implementing risk management measures that include developing a careful differential diagnosis that confirms the need for surgery and rules out contraindications, consulting with primary care physicians when patients have significant medical comorbidities or need to discontinue anticoagulant medications, conducting thorough informed consent discussions, and providing instructions to the surgical team about known risks.

A list of references for this article is available at [www.omic.com](http://www.omic.com).



# Closed Claim Study



## Monocular Patient Loses Vision After Vitrectomy

Ryan Bucsi, OMIC Senior Litigation Analyst

### Case summary

**A** 77-year-old female patient was referred to an OMIC insured with a history of blindness OS following a stroke several years earlier, as well as diabetes and hypertension. She had previous cataract surgery OD with 20/40 visual acuity and complained of seeing “specks.” The insured diagnosed marked asteroid hyalosis and, although the retina was attached, he recommended a vitrectomy to reduce the floaters. The insured was aware of the patient’s history of stroke and lost vision OS and that she was taking Plavix and aspirin, but he did not have her discontinue these medications prior to surgery. Towards the conclusion of the vitrectomy, the patient developed a bleed that led to a retinal detachment. Unable to isolate the bleed, the insured closed the eye and scheduled a subsequent procedure one week later to remove the blood and reattach the retina using silicone oil. It was noted during this second procedure that there was extensive clotting from the previous procedure. At this point, the insured consulted with the patient’s primary care physician, who decided to discontinue the Plavix. Two weeks later, a third procedure was performed to remove additional blood. The retina was detached for the removal of blood and reattached at the conclusion of the procedure, again using silicone oil. The insured then consulted with his partner as there was still some blood present in the eye and the retina continued to detach following each surgery. With the insured present, the partner performed a fourth surgery six weeks later in an attempt to remove all the remaining blood and reattach the retina. The surgery was successful in reattaching the retina, but all the blood could not be removed as the patient continued to bleed during the procedure. A final examination revealed a white optic nerve and indicated that blood underneath the retina for a prolonged period of time may have caused damage to the photoreceptors. The patient had nerve atrophy, atrophy of the eye itself, and NLP OD, rendering her completely blind.

### Analysis

Our defense experts were split on whether it was within the standard of care to operate on this patient without first consulting her primary care physician about safely taking her off Plavix and aspirin prior to surgery. However, our experts unanimously agreed that a separate informed consent should have been given to the patient specifically detailing the risk of hemorrhage, retinal detachment, and potential loss of sight. During his deposition, the insured testified that he had no discussions with the patient about an increased risk of bleeding, retinal detachment, and loss of vision because the vitrectomy was done in an avascular area and bleeding was not expected. Our experts disagreed and felt that bleeding was indeed a risk and since the patient had sight in only one eye, there should have been a more thorough review and discussion of all the risks associated with surgery. Indeed, the main weakness of the case was the apparent imbalance between the expected benefit of surgery to remove floaters and the potential risk of blindness in a functionally monocular patient.

### Risk management principles

The patient history and physical exam were appropriately performed and documented; however, the insured did not take into account that the findings indicated an increased risk for bleeding and retinal detachment, which could lead to blindness in the patient’s remaining good eye. The patient was never informed of these possible complications and did not have the opportunity to make a well-informed decision about moving forward with a procedure that carried significant risks. Additionally, as pointed out by one of OMIC’s defense experts, since this was an elective procedure, a detailed, well-documented discussion of the risks would have benefited the doctor when complications arose. OMIC has a sample consent form to use with surgical patients who are taking anticoagulants at [www.omic.com](http://www.omic.com).

### Allegation

Lack of informed consent of increased risk of bleeding during elective vitrectomy in a patient taking Plavix and aspirin.

### Disposition

Case settled for \$825,000.



## Preoperative History and Physical Examinations

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

**A**s the lead article explains, recent guidelines have helped clarify that patients cannot be “cleared” for surgery and that the purpose of the preoperative evaluation is to identify risks that need to be managed during the perioperative period. This *Hotline* article will address common questions about performing preoperative history and physical exams (H&Ps).

**Q** How extensive does the H&P need to be?

**A** Ophthalmic surgery has been deemed to be low risk, so eye surgeons are screening for medical conditions that could adversely affect the patient, especially those that involve the cardiovascular and respiratory systems and need to be mitigated before or monitored during surgery.<sup>1</sup> The history includes a review of systems and of medications. During the exam, the surgeon needs to review the vital signs and listen to the patient’s heart and lungs to screen for conditions that might warrant further evaluation by the patient’s primary care physician and/or anesthesia provider. Some ophthalmologists ask the patient’s PCP to send the results of the most recent complete physical exam to use as a baseline for the H&P, while others consult with the PCP only if their own H&P raises concerns. Ophthalmologists will need to use professional judgment in deciding when to consult with other physicians or refer the patient to a PCP. Many patients undergoing eye surgery are older and most have medical conditions. Nonetheless, patients who are reliable historians and are reportedly stable may not need to be referred unless the ophthalmologist

determines that the medical regimen may need to be changed to reduce the risk of perioperative complications (see the lead article for a discussion on anticoagulants).

**Q** Are there other measures of a patient’s ability to withstand surgery that ophthalmologists should consider assessing?

**A** Yes. Eye surgeons can evaluate their patient’s functional capacity, a measure based upon the patient’s reported ability to perform a spectrum of common daily tasks ranging from self-care, slow walking, light housework, stair climbing, and rapid walking, to heavy housework, moderate recreational activities, and strenuous sports. Studies cited in the guidelines indicate that functional capacity correlates well with maximum oxygen uptake by treadmill testing.<sup>2</sup> Patients with very limited functional capacity may have undiagnosed or undertreated cardiac, medical, or pulmonary conditions and may need to be evaluated by their PCP. In any event, information about the patient’s functional capacity can be included in the H&P report that is sent to the surgery center or hospital.

**Q** May I delegate the preoperative H&P to licensed staff, such as registered nurses, nurse practitioners, and physician assistants?

**A** Yes, the scope of practice and skill set of these providers allows them to perform these exams. If the licensed person conducting the exam is your employee, you will likely have vicarious liability for his or her care and are expected to supervise it. Registered nurses will require the most guidance and supervision.

You will need to develop a written protocol that provides guidance on the questions to ask during the review of systems and the extent of the exam. You are responsible for reviewing the completed H&P and determining the patient’s ability to proceed with surgery. Follow up on positive H&P findings, determine the need for consultations or referrals, date and sign the document, and communicate the results to the anesthesia provider. Address any concerns raised by the H&P directly with the patient as well.

Nurse practitioners (NPs) and physician assistants (PAs) routinely conduct comprehensive H&Ps, so they will not need guidance in how to perform them. They tend to be employees of a surgery center rather than of an ophthalmologist and may be performing the preoperative H&P or the reassessment on the day of surgery. If you are asked to sign a report prepared by an NP or PA who is not your employee, your signature acknowledges that the patient’s medical condition has been evaluated, but does not imply that you are attesting to the accuracy or thoroughness of the examination in question. Once such an NP or PA has completed the H&P or reassessment, read it and write “Patient (re)assessed for surgery by \_\_\_\_\_ NP/PA” (include the provider’s name and title).

1. Zambouri A. “Preoperative Evaluation and Preparation for Anesthesia and Surgery.” *Hippokratia*. 2007 Jan-Mar; 11(1): 13–21.

2. ACC/AHA “Guidelines on Perioperative Cardiovascular Evaluation and Care for Noncardiac Surgery.” *Circulation*. 2007; 116:e418-e500.



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## Calendar of Events

OMIC is offering a variety of risk management courses throughout the spring. Upon completion of an OMIC online course, CD/DVD, or live seminar, OMIC insureds receive one risk management premium discount per premium year to be applied upon renewal. For most programs, a 5% risk management discount is available; however, insureds who are members of a cooperative venture society (indicated by an asterisk) may earn an *additional discount* by participating in an approved OMIC risk management activity. Courses are also listed on the OMIC website, [www.omic.com](http://www.omic.com).

Contact Linda Nakamura at 800.562.6642, ext. 652, or [lnakamura@omic.com](mailto:lnakamura@omic.com) for questions about OMIC's risk management seminars, CD/DVD recordings, or computer-based courses.

### NEW!

**My Doctor Never Told Me That Could Happen!** Webinar available to OMIC insureds at no charge. Contact OMIC's risk management department for more details.

### APRIL

**26 OMIC's Experience with Malpractice Issues Surrounding ROP.** Current Trends in ROP Management & Research. Marriott Courtyard Washingtonian Center, Gaithersburg, MD. Contact organizers at <http://www.ropupdate.com/>.

**27 Refractive Surgery on Trial.** American Society of Cataract & Refractive Surgery. Boston Convention & Exhibition Center, Boston, MA; 3–4:30 pm. Register with ASCRS at 703.591.2220 or <http://annualmeeting.ascrs.org/>.

### MAY

**2 Identifying and Managing Unhappy Patients.** Texas Ophthalmological Association.\* OMNI Fort Worth & Fort Worth Convention Center, Fort Worth, TX; 12:45–2:15 pm. Contact TOA at 512.370.1504.

**10 Identifying and Managing Unhappy Patients.** Kentucky Academy of Eye Physicians & Surgeons.\* 21C Museum Hotel, Louisville KY; 7:30–8:30 am. Contact KAEPs at 317.577.3062.

### JUNE

**7 How Is Your Documentation?** Virginia Society of Eye Physicians & Surgeons.\* The Jefferson Hotel, Richmond, VA; time 2–3:30 pm. Register with VSEPS at 804.261.9890 or go to <http://vaeyemd.org/>.

**13 Medical Error: Risk Management and Ethics.** Contact Lens Association of Ophthalmologists.\* InterContinental Toronto Centre Hotel, Toronto, ONT (Canada); 2–3 pm. Register with CLAO at 855.264.8818 or go to <http://toronto2014.claa.org/toronto2014-home>.

**13 Concepts and Challenges with Comanagement.** Connecticut Society of Eye Physicians.\* Aqua Turf Club, Plantsville, CT; time TBA. Register at <http://connecticutsocietyofeyephysicians.com/meetings.html>.

**22 Legal and Ethical Considerations of Informed Consent.** American Society of Ophthalmic Plastic & Reconstructive Surgery.\* Montage Deer Valley, Park City, UT; 9–10 am. Register at <http://www.asoprs.org/i4a/pages/index.cfm?pageid=3587>.