WHEN A NIGHTMARE IS DRESSED LIKE A DAYDREAM

What happens when a seemingly straightforward surgery becomes surgically (and legally) complex?

BY JONATHAN D. SOLOMON, MD

In our careers as surgeons, we will all, at some point, face incredibly complex cases. Surgical challenges will inevitably arise, and we will be forced to pull out all the stops to make recoveries in the OR. Fortunately, we have a range of incredible technologies and techniques at our disposal to help when things do not go exactly as planned.

On occasion, though, a seemingly straightforward surgical case can go awry due to unforeseen circumstances. For the particular case detailed in this article, there was no machine that could have saved me from what I was to face. In truth, there was nothing about this case that indicated it would be anything other than a home run. But, as I would come to find out, sometimes a nightmare case can, in fact, be dressed like a daydream.

THE SURGICAL SCENARIO

Years ago, a patient was referred to me by her optometrist for what appeared to be a straightforward cataract in one eye. Eliminating all other potential causes such as trauma or medications, I determined it to simply be one of those cases of unilateral cataract. The patient was myopic and had a dense posterior subcapsular cataract and a fair amount of with-the-rule astigmatism. Visual acuity in her other eye was 20/20.

The optometrist indicated that the patient wanted a toric IOL. When she and I got to talking, she described a desire to achieve near-total freedom from glasses. During that conversation, we also discussed the option of a multifocal IOL. Normally, I do not discuss multifocal IOLs with patients who have that much astigmatism, but I indicated that this might be a bioptic scenario, in which we might be looking at a potential enhancement down the road.

The patient had upward of 1.50 D cylinder by all three keratometric measurements (SimK, OrbScan [Bausch + Lomb], and OPD III [Nidek]). Keep in mind, this was before we were using Cassini (Cassini Technologies) and Streamline with the Lensar Laser System (Lensar). However, we were running aberrometry with the ORA System (Alcon) and had seen that there were differences in the actual intraoperative measurements, so we were trying to pay attention to that.

As evidenced by the IOLMaster (Carl Zeiss Meditec) report, I was considering a few different options, which the patient and I had discussed when reviewing the various technologies during her preoperative assessment. The patient initially said that she wanted a multifocal IOL, so my thinking was that clearly I would have to do some arcuate incisions and there may very well be a need for enhancement.

In this case, we used our typical lifestyle questionnaire, which is helpful not just to get an idea of the patient's understanding of the technology but also to get an understanding of the patient. In retrospect, the patient was somewhat quiet yet direct, but I didn't think that was unusual. She wasn't a terribly vivacious individual and wasn't terribly excited about the process, but I figured maybe she was nervous. I did not necessarily see her as cold, but I remember my nurse remarking that she was a slightly grumpy woman. Again, I didn't think too much of it at the time.

In speaking with the patient's optometrist, which is what I typically do, I reviewed my plan, my options, and the patient's goals and perspective. The patient had mentioned to me that, in the past, she had been quite happy with monovision. With that tidbit in mind, I thought maybe we could focus more on her astigmatism in order to achieve an outcome that was more consistent with her past experience as well as a more appropriate long-term goal.

I mentioned to the patient that she might need surgery on the contralateral eye. My thinking was that, because she was 50 years old, we might start to see a drift against the rule, so maybe undercorrecting her would be a good idea. Quite honestly, in retrospect, I may have been overthinking this. But, needless to say, we went through our usual advanced beneficiary notice and consent forms,

which describe our surgical approach and alternatives.

In our review of astigmatism, we mention both arcuate incisions and toric IOLs and state that the intention is obviously to reduce astigmatism. We do not say things like: "We are going to eliminate your astigmatism." We maintain that the objective is to try to achieve a level of happiness and satisfaction, and we will do whatever we feel is safe and appropriate to achieve those goals.

REVIEWING THE PLAN

Once again, we reviewed our plan to correct the patient's astigmatism and to try to achieve a goal of computer correction. We talked about the different options (or at least that was my impression of our conversation).

We went forward with uncomplicated laser cataract removal with the idea that we could have used a toric IOL, but as she ages that lens is not going to age, and we want to ensure that, if there is a drift, she is able to work with that; therefore, arcuate incisions were delivered. We had just started doing arcuate incisions and had seen pretty good results. We chose a biaspheric lens with the idea of achieving an extended depth of focus.

Titrating the incisions based on intraoperative aberrometry, in accordance with published reports,[1] I thought we had effectively addressed the astigmatism. I did not worry about the spherical component, but the ORA was saying that there was not much cylinder.

THE POSTOPERATIVE COURSE

At the 1-week postoperative visit, the patient reported a little difficulty reading her phone. Well, we were trying to shoot for a computer—different distance, right?—and she said that her computer vision was OK. Her near UCVA was J2 and 20/15 at 32 inches. I was reading this on the patient's chart, as my postoperative eye care provider handles a lot of the postoperative day 1 and week 1 evaluations, and I step in to review things moving forward.

The patient came into the office for an unplanned visit 2 weeks after surgery. We got to talking, and she said, "During surgery, I heard someone say, 'Do you need a toric lens?' and you responded, 'No.'" Now, it is certainly possible that happened, although it is typically a conversation that we have beforehand. We were looking at the numbers, and the intention was to consider all options. I told the patient that we are always going to consider our primary goal, and, in our practice, the end game is not to have the patient buy a specific lens but to achieve a particular outcome. The patient returned to her optometrist to discuss this further. I received a phone call saying that she was very upset with her outcome and that she did not get the toric IOL that she thought she had bought.

At her 9-week postoperative visit, there was no real change. She had a little bit more cylinder. Playing on my own vanity, I thought we were going to correct all of the astigmatism. As a general rule, we do very well, but there will always be those outliers and situations in which we do not quite hit the target.

Now, did I think the astigmatism was the cause of her dissatisfaction? Not at this point, as, based on the numbers, she seemed to be doing pretty well. However, I still felt that we owed her everything in our armamentarium to try to correct that astigmatism in the event that it was the cause of her dissatisfaction.

ENHANCEMENT

All of the numbers reported that we had gotten her below 1.00 D. Three months after her initial surgical encounter, we went ahead and enhanced the arcuate incisions. We were able to get her around 0.75 D with the rule, with the idea that, again, she was 50 years old, and things would change over time.

Following her enhancement, the patient continued to ask why we did not place a toric IOL. Again, it did not matter what we said to her and how she was seeing. It was simply, "Why didn't I get the toric lens?"

After having a conversation with her about a potential LASIK enhancement, it dawned on me that we were never going to make this patient happy. So I communicated that. I said, "We could certainly move forward with LASIK, but I don't think that my doing LASIK at this point or at any point down the road is going to make you comfortable with the services we have provided."

We offered her a refund, which she immediately accepted. We had her sign paperwork outlining our agreement and our options. Additionally, our practice director, who is an attorney, vetted this whole process and did the best she could to explain the scenario to the patient.

WATCH IT NOW

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WAIT, WHAT?

Eighteen months later, I received a letter from the patient requesting money. (Remember, she was refunded for her initial procedure, and we offered to perform laser vision correction.) Well, I can't imagine the patient didn't know, because my name is on the door to the office, but I also practice at a busy laser vision center, where she ended up unknowingly asking my partner for a LASIK enhancement. I got a call saying

"WHEN THE STATE MEDICAL BOARDS GET INVOLVED, YOU MUST TAKE IT SERIOUSLY. IT WILL TAKE SOME COACHING AND SOME CALMING DOWN."

that a patient of mine who had surgery was there, asking for PRK. In her letter, the patient said she wanted me to pay for the PRK. We respectfully replied, stating that we felt we had fulfilled our duties and were not comfortable paying anything moving forward.

Twenty-four months later, I received another letter, but it was not from the patient—it was from the Maryland Board of Physicians. The patient claimed that I had breached my contract, that I was dishonest in my delivery of care, and that I had caused her to miss work and spend extra days during surgery that she would have not had to do if I had done my job correctly. She requested disciplinary action. I communicated with my malpractice insurance carrier and immediately retained legal counsel at the urging of my wife. My wife, herself an attorney, said, "You might want to call an attorney." So I called Allison Shuren, JD, MSN.

SERIOUS RAMIFICATIONS

There are some serious potential ramifications in these kinds of legal matters. When the state medical boards get involved, you must take it seriously. It will take some coaching and some calming down. When this letter arrived, my heart sank—forget about a dropped lens or anything else that goes wrong in the OR. As physicians, we always try to do our best. Nobody sets out do anything wrong, but sometimes situations like this end up at our doorsteps (really, the board's letter came to my house).

In summary, our reply letter stated that clearly we do our best to provide patient outcomes using evidence-based medicine, try to achieve goals that are best not only from a medical standpoint but from a patient satisfaction standpoint, and are always striving to do a better job. We also detailed some of our corrective actions to show what we were doing differently to improve our care. We indicated that we now have a consent form that is signed at the time of the patient's surgical consultation and then a repeat consent of the same form before we walk into the OR. If patients change their minds at the time of surgery, we have them sign that form to verify the change of plans.

We have since implemented CheckedUp to enhance our patient education process. With this system, patients do not simply watch an animated video about their treatment options but actually interact with the content. To finish a video, they have to push a button to continue. The video clearly outlines my surgical approach, and it is personalized, with me introducing myself and the practice. In essence, the CheckedUp process is almost like another way of vetting the consent form. Patients indicate that they understand the technology and their options, and they then get a report, as do we, stating that they went through the information appropriately. CheckedUp has changed the way patients understand our presurgical consultations, so it is a tool that has been unbelievably valuable to my practice in the short term.

With that in mind, I got a reply letter from the board 4 months later. By that point, this had been dragging on for more than 2.5 years. Fortunately, the board offered a thorough review of the complaint, our response, and other pertinent materials and ultimately decided to close the matter without further action.

IN HINDSIGHT

Although legally the matter was resolved, this experience continued to weigh on me, so I thought about how to use it constructively to improve my practice. We paid attention to what the Maryland Board of Physicians said, which was to be extremely transparent about everything that is done pre- and postoperatively.

Toric IOLs are synonymous with astigmatism correction in a lot of people's minds—particularly referring eye care providers, in my experience. We now send out a laminated card that states my surgical preferences—when I am likely to transition to a toric lens, when I am not, and what my goals are in the process. It is important that this information be well documented and communicated.

One other lesson I learned from this is to be careful what I say in the OR. I do not necessarily feel that the comment made during the patient's surgery was negative, but it was up for the patient's interpretation.

Communicate with the patient and the referring optometrist. As the surgeon, you, and not a counselor, should be the one to handle important discussions with the patient.

And when all else fails, make sure you have good legal representation. ■

1. Packer M. Effect of intraoperative aberrometry on the rate of postoperative enhancement: retrospective study. *J Cataract Refract Surg*. 2010;36(5):747-755.

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