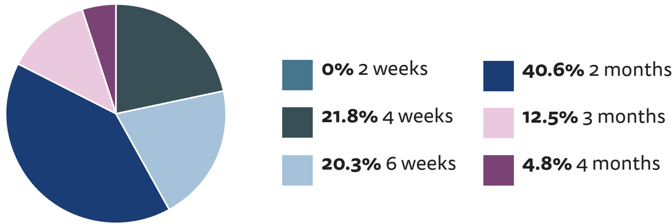
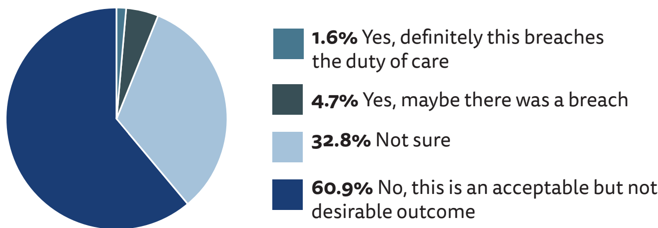
The results of the last survey

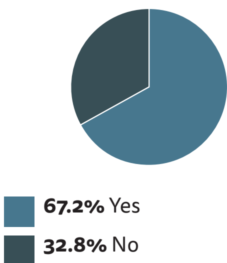
In a moderate glaucoma case where progression has been detected at a pressure in the low 20s and you change / add drops, how soon would you follow the patient up?



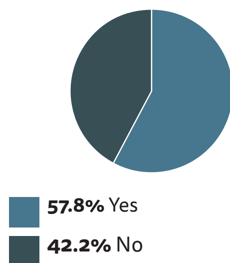
Faced with a case of a shallow anterior chamber and IFIS leading to iris damage, corectopia and cystoid macular oedema, would you consider the surgical management of the patient to have been negligent?



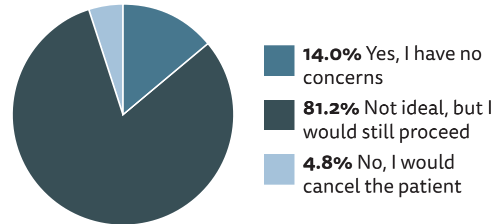
When undertaking intravitreal injections do you routinely warn about lens touch and cataract?



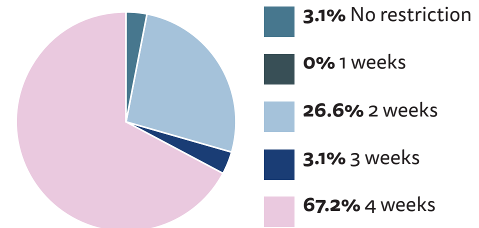
Assuming a pooled operating list and you are the operating surgeon who has not seen or clinically examined the patient before, do you re-examine them at the slit-lamp?



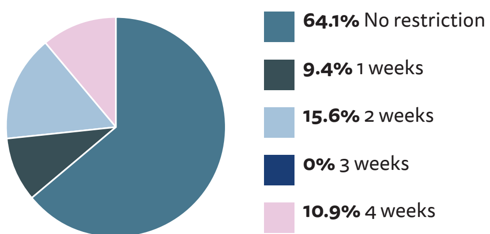
Assuming you are the operating surgeon and the patient was seen by someone else in clinic but no consent form was signed, do you think it is acceptable to get the patient to sign the consent form on the day immediately prior to their surgery?



Assuming routine cataract surgery, how long should the patient refrain from swimming with goggles?



Assuming routine cataract surgery, how long should the patient refrain from flying?



appreciate that I keep on reiterating it, but again we see so much practice variance. Who is right and who is wrong? Is there a right or wrong approach? And does it matter?

I think it probably does matter. We live and work in a healthcare system with limited resources and we need to use them wisely. We also need to ensure equity of care so that wherever in the country a patient is being looked after they can expect the same standard of care.

The question regarding follow-up was interesting in that the variance was from four weeks to four months. I deliberately chose a moderate rather than advanced case. My practice is that I bring patients back in two months to assess them. I would love to bring them back in four weeks, but the clinic load is too great to facilitate that. Forty percent of respondents agree with me. I personally think that four months is too long. You have made a clinical decision that the patient is progressing and we are well aware of a non-response rate to topical medication and, therefore, playing the role of a solicitor for a complainant, you are "leaving the patient for four months with potentially progressive glaucoma, which will manifest as irreversible damage".

The second question is highly pertinent to litigation. I have had cases of mine whereby the iris was floppy and despite five hooks and intracameral phenylephrine there was still iris prolapse and the iris was sadly mashed up. Was I negligent? I did my best and despite all my efforts we still ran into problems. If you are going to call me negligent because there were complications and the outcome was not ideal, I will stop doing the complex cases and we will move to a risk-averse American system. The key question is; faced with a similar case would a reasonably competent ophthalmologist have encountered the same difficulties, and would the outcome have been the same? I am confident that the answer is yes. Six percent of respondents felt there was or may have been a breach. I think that that is harsh. A third were unsure. As a medico-legal 'expert' I am faced with making a decision on whether there was a breach. The final 'decision' is the remit of the court but my duty is primarily to that court regardless of who instructs me.

There is some work on going about consent for intravitreal and cataract procedures. The next survey will focus on consent for cataract surgery and I urge you to be involved as it is a matter of vital importance for all ophthalmologists.

The question on lens touch is important. Two-thirds of respondents do warn about lens touch and one-third do not. Historically this would have protected those third who do not warn about lens touch as a responsible body of opinion did the same however consent has evolved and now the Bolam

test does not apply to consent. The patient should be informed of all 'material risks'. The question I would ask you is; if two thirds of your colleagues do warn about lens touch, could it not be said that it is a material risk and therefore should be mentioned? I do not routinely undertake intravitreal injections so my opinion is superficial, but that is the sort of question we should all be asking ourselves about our practice.

The split was roughly down the middle as to how many surgeons re-examine the patient before they operate. I undertake high volume lists of 10 or more and the logistics of re-examining each patient would make such a high-volume list impossible. I trust the clinician who has seen the patient in the clinic that their findings are accurate. Unless there has been a sudden change in the vision or the patient complains of new symptoms then I do not look at them on the slit-lamp but simply mark them and eyeball (excuse the pun) the eye.

Consent rears its head again in this next question. We know that best practice is not to consent on the day and indeed there have been medico-legal cases (not in eyes) where this was a major issue and breach of duty was admitted. Ideally patients need time to digest the information that you have provided and the opportunity to discuss it with friends and relatives. The time to discuss complications is in the clinic when the patient is not feeling pressurised and has time to ask questions. I do not think it is ideal to scare an already anxious patient with a list of complications when they are already there for the procedure. If the patient is coming as a one-stop (surgery same day as consultation), I think it is important to make sure they have had information in advance so they can consider the risk-benefit profile of their intended surgery.

There are many cases of litigation I see on a monthly basis whereby patients were asked to sign on the day and they deny that they were told anything about the risks. Common phrases I see in claimants statements are "I had drops put in so I could not see clearly and then I was just handed a form to sign", "I was given a form to sign but the risks were not discussed with me", or "I was told the risks but it was too late for me to do anything about it as I was already in the anaesthetic room".

The final two questions highlight the massive variability in the advice we give our patients after cataract surgery. Although for us it has little impact, for the patients it can have a significant impact on their lives. Ten percent of respondents tell their cataract patients that they cannot fly for a month. This will impact adversely on holidays and plans to visit family etc. Why does one surgeon indicate no restrictions but another state a month? Personally, I ask them not to fly away in the first two weeks after surgery as this is a critical period for postoperative complications and I would rather they were around for me to look after them in case they run into problems. Furthermore, I always warn them that if something does go wrong and I need to keep them their travel insurance company may not cover it as the operation was elective.

Finally, the swimming issue. I tell my patients to refrain from swimming completely for two weeks and then go back to it after two weeks with goggles and then four weeks without goggles. I have no evidence base for this whatsoever and cannot recall where I got these figures from. My rationale is that the swimming pool water has all sorts of nastiness in it and I would rather my patients do not bathe their fresh corneal wound in it until it is reasonably sound. I do not like the idea of goggles in the first two weeks as when I wear goggles, they can sometimes put pressure on the eye itself. After two weeks I think the eye is robust enough to take a bit of pressure but not so fully healed as to not worry about it being soaked in pool water.

Is there a correct answer? Should we have consensus views on these issues? I am not clever enough to know.

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Our next survey: Focus on cataract consent

1. Do you use a pre-printed cataract consent forms for the majority of your work?
- ❑ Yes
- ❑ No

2. Assuming an 'ordinary' cataract patient, e.g. 75-year-old emmetropic patient with no comorbidity and an NS 2+ cataract in both eyes.

Potential items on consent form:

a) 1:1000 risk of severe or permanent visual loss
b) 1:100 risk of need for further surgery including the risk of the lens falling to the back
c) 1:20 complications during surgery that can be rectified at time of surgery or following the operation
d) 1:10 need laser at some future point in time
e) Need for glasses or contact lenses / refractive error
f) Dry eyes
g) Rupture of the bag holding the lens potentially meaning no lens can be placed
h) Rupture of the bag holding the lens in place resulting in jelly coming forward
i) Iris damage due to floppy iris
j) Cystoid macular oedema
k) Corneal decompensation
l) Infection
m) High pressure and glaucoma
n) Retinal detachment
o) Posterior capsular opacification / Need for laser treatment
p) Need for further surgery
q) Need for reading glasses
r) Double vision
s) 1:10,000 risk of sympathetic ophthalmia

For each of the above:

- Do you consent for this?
  - ❑ Yes
  - ❑ No
- Should we consent for this?
  - ❑ Yes definitely
  - ❑ Yes possibly
  - ❑ Unsure
  - ❑ No
- Do you believe the patient will fully understand this complication?
  - ❑ Yes definitely
  - ❑ Yes possibly
  - ❑ Unsure
  - ❑ No
- How important do you think this complication is for the 'reasonable' patient?

  1 10*

  ❑❑❑❑❑❑❑❑❑❑

3. How long do you feel it is reasonable to spend on solely the consent portion of the consultation?
- ❑ Less than 5 mins
- ❑ 5 mins
- ❑ 10 mins
- ❑ 15 mins
- ❑ 20 mins
- ❑ More than 20 mins

4. Do you think a patient wants to know every potential risk?
- ❑ Yes
- ❑ No

5. If a patient does not want to know any risks should you abide by their wishes?
- ❑ Yes
- ❑ No
- ❑ Unsure

6. If a patient suffers a complication not on the consent form do you believe it is a breach of duty?
- ❑ Yes
- ❑ No
- ❑ Unsure

*scale 1 to 10 (1 not important to 10 very important)

You can complete the survey online here: www.eyenews.uk.com/ophthalmology-survey-focus-on-cataract-consent/
Results of previous surveys are also available on the website: www.eyenews.uk.com/education/medico-legal/