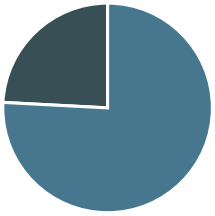
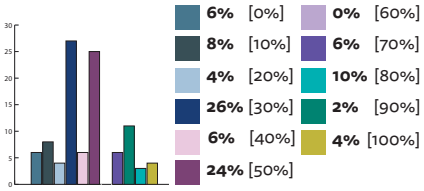
The results of the last survey

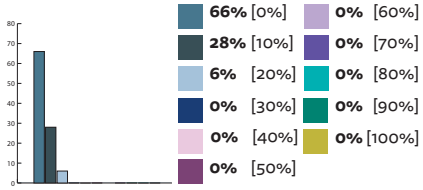
1. Are you currently undertaking general ophthalmology clinics?



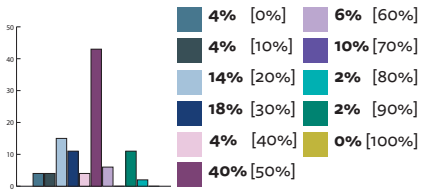
2. Currently, how many of your consultations are carried out – Face to face?



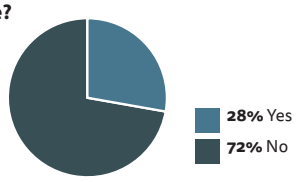
3. Currently, how many of your consultations are carried out – Virtually via video?



4. Currently, how many of your consultations are carried out – Virtually via telephone?



5. Do you have access to a local non-hospital / optometry or other service which can measure IOPs and feed these readings back to the hospital eye service?



Assuming you are doing a telephone clinic and you telephone a 71-year-old man with mild COPD who is a driver and has established glaucoma and an MD of -14.4dB in one eye and -3.1dB in the other eye. Presenting pressure was 25mmHg. The lockdown is still active. What is your management?

(Applies to questions 6 to 12)

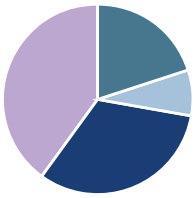
Possible responses - shortened next to charts

- Bring in for face to face appointment and IOP check before lockdown ends (less than one month)
- Change / add topical medication remotely
- Reassure + f/u in 2 months when lockdown restrictions abate
- Reassure + f/u in 3 months when lockdown restrictions abate
- Reassure + f/u in 4 months when lockdown restrictions abate
- Reassure + f/u in 6 months when lockdown restrictions abate
- Send to optometrist or community service for IOP check (if available)

6. IOP had been stable at 15mmHg on one drop for some years but at the last attendance three months earlier the IOP was 24mmHg. No change in therapy was planned and the aim was to bring him in for a recheck of IOP.

- **18%** Face to face appt
- **46%** Change / add topical m
- **12%** Reassure + f/u in 2 months
- **24%** To opto or community service

7. Same patient as in question 6, however a second drop was added.



- **20%** Face to face appt
- **8%** Reassure + f/u in 2 months
- **32%** Reassure + f/u in 3 months
- **40%** To opto or community service

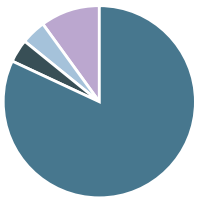
8. IOP had been stable at 15mmHg on one drop for some years but at the last attendance three months earlier the IOP was 34mmHg. An additional drop was added.

- **82%** Face to face appt
- **4%** Reassure + f/u in 2 months
- **14%** To opto or community service

9. IOP had been creeping up on one drop for some years and at the last attendance 6 months previously the IOP was 20mmHg. A suspicion of visual field progression was raised.

- **14%** Face to face appt
- **6%** Change / add topical m
- **34%** Reassure + f/u in 2 months
- **36%** Reassure + f/u in 3 months
- **4%** Reassure + f/u in 4 months
- **6%** To opto or community service

10. IOP was 39mmHg at the last visit 2 months earlier and it was suspected this was due to poor compliance. Review was arranged for 6 weeks later.



- **82%** Face to face appt
- **4%** Change / add topical m
- **4%** Reassure + f/u in 2 months
- **10%** To opto or community service

11. IOP had been stable at 15mmHg on one drop for some years. At the last follow-up the IOP was 16mmHg and a follow-up in a year was arranged. This has already been delayed and is now 18 months.

- **10%** Face to face appt
- **16%** Reassure + f/u in 2 months
- **40%** Reassure + f/u in 3 months
- **16%** Reassure + f/u in 4 months
- **4%** Reassure + f/u in 6 months
- **14%** To opto or community service

12. IOP had been stable at 15mmHg on one drop for some years. At the last follow-up the IOP was 16mmHg and a follow-up in a year was arranged. This has already been delayed and is now 18 months. The patient tells you that the IOP was 24mmHg at their opticians just before lockdown.

- **46%** Face to face appt
- **14%** Change / add topical m
- **28%** Reassure + f/u in 2 months
- **6%** Reassure + f/u in 3 months
- **2%** Reassure + f/u in 6 months
- **4%** To opto or community service

13. Considering the above scenarios, assume the clinician did not bring the patient in for an IOP check face to face and they finally attend with a bilateral IOP of 35mmHg and progression of the visual field defects in both eyes resulting in loss of driving license. They complain that no effort was made to check their IOP at their booked appointment. Do you consider that:

- **30%** The standard of care was reasonable due to the restrictions of the coronavirus lockdown
- **36%** There was an unavoidable breach of duty in not attempting to measure the IOP or delaying the follow-up
- **34%** There was an avoidable breach of duty in not attempting to measure the IOP or delaying the follow-up

Complete the next survey online here:

www.eyenews.uk.com/survey/

Deadline 30 Aug 2020

Results of previous surveys: www.eyenews.uk.com/education/medico-legal/

Once more I would like to thank those of you who took the time to complete the last edition's survey. It was highly pertinent to what we are facing now.

It is clear that our services have been markedly disrupted. Three quarters of us are seeing 50% or less of our patients face to face in clinics, with a lot of us telephoning patients for their consultations. I have done my fair share of trying to guess the intraocular pressure (IOP) from the timbre of the patient's voice over the phone and the jury will remain out for some time as to whether I am getting it correct.

Only one quarter of us have access to some other mechanism to check patients IOPs which I think is concerning.

The clinical scenario I presented to you is common. A patient who was stable and 'low risk' on one drop who was due for a clinical review to check them has been hamstrung by the lockdown.

When faced with our hypothetical stable patient we assessed the clinical record and found that their IOP was 24mmHg at their last attendance and they were due for a recheck which was cancelled by COVID-19 issues. Almost half of responders would have given topical medication remotely without seeing the patient again. A quarter would have organised a face to face (F2F) appointment within two months and a quarter would have asked the patient to attend an optometry or community service for an IOP check. My personal view is that all of these options are entirely reasonable.

When a second drop was added at the last visit, we need to check efficacy. We know there is a non-response rate, however, on the balance of probabilities, we can reasonably assume that there was some response and the IOP should have come down. Even if there was not a massive response an IOP of 24mmHg is unlikely to cause a rapid deterioration. Forty percent would be happy with a community IOP check, while one-fifth would bring the patient in within a month for a F2F appointment.

Now the IOP is higher at 34mmHg and there are clear clinical risks if the IOP does not respond. In this scenario the majority would bring the patient in for a F2F review. But this is not universal and there are some clinicians who would still bring patients back in two months. If at that time the IOP was 40mmHg would they be protected as having acted reasonably?

When the IOP was still not particularly high but there was a suspicion of visual field progression, the majority of clinicians would arrange an appointment for two to three months. I think this is reasonable as glaucoma progresses slowly and the IOP was not particularly high.

When faced with an IOP of 39mmHg and suspected poor compliance the majority would have brought the patient in for a review within one month. Some would add a drop remotely but if they are already non-compliant it seems strange to expect them to use an extra drop.

When we are considering a patient who has been stable and has already had their appointment delayed, the view on what we should do starts to broaden. We planned to see this patient at a year. They have already been delayed, which we know is a problem and is causing visual loss. The patient remains low risk but not no risk. If their IOP had gone up gradually then they could be sitting with an IOP of 32mmHg for more than a year now. Approximately a quarter would prioritise this patient and bring them in in one or two months. More than half would bring the patient back in three to four months, meaning their final F2F and IOP check is potentially almost a year delayed.

In the next scenario we know that the IOP has gone up as it was checked by the optician. This changes practice and now the follow-up is much tighter. The only difference between this case and the one above is that they happened to go to their optometrist for an eye check before lockdown and they measured the pressure as being high. Is it better not to know the true pressure, as in the previous case? Does that mean that these two cases deserve different management because we do not know what the pressure is?

The final question deserves reiterating. "Considering the above scenarios, assume the clinician did not bring the patient in for an IOP check face to face and they finally attend with a bilateral IOP of 35mmHg and progression of the visual field defects in both eyes resulting in loss of driving license. They complain that no effort was made to check their IOP at their booked appointment." How should we as a professional body respond? How should the expert witnesses and the Courts interpret the situation? Does the coronavirus crisis give us enough leeway to protect ourselves from these undesirable decisions we are making?

Thirty percent of respondents felt that the standard of care was reasonable due to the restrictions of the coronavirus lockdown. Thirty-six percent of responders felt that there was **unavoidable** breach of duty in not attempting to measure the IOP or delaying the follow-up.

So, two thirds of the respondents would excuse the decisions based on the fundamental and unprecedented pressures we have faced due to the coronavirus and I would be sympathetic with that, but would the Courts?

A third felt there was an **avoidable** breach of duty in not attempting to measure the IOP or delaying the follow-up. If one third of our respondents felt that then what should the Courts believe, and will we be criticised when judgment day comes?

I hope that this stimulates thought and debate about the standard of care we are providing and we ensure that we are doing our best for the patients. As ever, some guidance from those much wiser than me would be welcome.

SECTION EDITOR

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Our next survey:

1. Do you have an anterior chamber IOL calculation on your biometry for routine cases?
   - ❑ Yes ❑ No
2. Assuming a newly diagnosed glaucoma patient who is a driver. When do you advise them to inform the DVLA of their glaucoma diagnosis?
   - ❑ Immediately even with no visual field defect
   - ❑ Only if there is visual field defect in one eye
   - ❑ Only if there is a visual field defect in both eyes even if there is no clinical concern that they would meet the driving threshold.
   - ❑ Only if there is a visual field defect AND it is your opinion that they would be below or borderline for the driving threshold.
3. Assuming a patient who is attending for their second eye cataract surgery who had uncomplicated surgery for their first eye within the last four months, regarding the consent process, do you:
   - ❑ Go through all the risks and benefits of surgery again as if it were the original consent?
   - ❑ Explain the basic risks and get the patient to sign the consent form?
   - ❑ Assume the patient has an intimate understanding of the risks and benefits of surgery and get them to sign the consent form once you are happy they have confirmed their wish to proceed again?
4. Regarding local anaesthetic for cataract surgery. What sort of anaesthetic do you usually use for routine cases?
   - ❑ Solely topical
   - ❑ Solely topical and intracameral
   - ❑ Some topical and some sub-Tenon anaesthesia but mostly topical
   - ❑ Some topical and some sub-Tenon anaesthesia but mostly sub-Tenon anaesthesia
   - ❑ Solely sub-Tenon anaesthesia
5. When using sub-Tenon anaesthesia do you (or your regular anaesthetist) use:
   - ❑ Pure local anaesthetic?
   - ❑ Local anaesthetic with hyalase?
   - ❑ Local anaesthetic with adrenaline?
   - ❑ Local anaesthetic with hyalase and adrenaline?
6. When operating in a community setting (no arrest team available) do you have an anaesthetist with you on your operating lists?
   - ❑ Yes ❑ No
7. When operating in the acute Trust (arrest team available) do you have an anaesthetist with you on your operating lists?
   - ❑ Yes ❑ No