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OPINIONS & COMMENTARY

What's happened to refractive surgery?

by C. Gregory Tiemeier, Esq.

When Leo Bores M.D., introduced refractive surgery to the United States in 1979 it was a novelty. Radial Keratotomy (RK) promised an alternative to glasses or contact lenses, but at the price of unpredictability, unknown risks, and heavy reliance on the manual dexterity of the surgeon. RK's popularity waxed and waned over time, but was never practiced by more than 10% of the ophthalmic population.

In every RK malpractice lawsuit I defended, I would face at least one expert witness who wanted to debate the propriety of performing surgery on a "healthy" eye, and the subject was also debated in the ophthalmic literature. I have yet to hear any expert witness in a LASIK case question whether it was appropriate to consider operating for myopia or hyperopia, assuming no contraindications. With the impending approval of phakic intraocular lenses, refractive surgeons will not only operate on a "healthy" eye, but will enter the globe to do so.

This change in attitude stems from many advances, including accuracy, predictability, and improved ability to diagnose conditions that may contraindicate or complicate the refractive procedure. These advances in turn allow the ophthalmologist to offer patients a higher degree of safety and satisfaction, which has increased the popularity of refractive surgery, and increased the opportunities for a profitable refractive practice.

The flip side of all this good news is a fundamental change in the way patients think of the operation itself. Refractive surgery is now advertised so regularly, with such enthusiasm, and with so many euphemisms, that an unsophisticated observer reading a newspaper advertisement may walk away with no appreciation that this really is surgery. The packaging of LASIK and other new refractive procedures has created a host of issues that have little to do with the surgical aspects of the procedure, but everything to do with staying out of legal trouble. The following are some suggestions on how to deal with them.

The commoditization of refractive surgery

In the fall of 2000, I received an advertising brochure from a local ophthalmologist who specializes in refractive surgery. He is well-regarded by his peers and highly experienced in refractive surgery. The brochure was professionally created, and looked tasteful and informative. On the inside, however, were four tear-out coupons for "Save! $400 OFF LASIK " both eyes" and "Have LASIK with a friend or family member " Buddy Program " $600 OFF LASIK " Per person." The coupons even had yellow "splashes" that urged the reader to "HURRY! " Offer Expires 12/31/00."

Given the intensity of LASIK marketing in the Denver area, this did not seem atypical. But think about it for a moment " coupons for dollars off a surgical procedure? Bring a friend to have surgery too? The pamphlet did not once mention that LASIK was surgery, only a "procedure," although it did mention that "cataract surgery" was also done at the facility.

Six months later, the same surgeon was quoted in the local newspaper, lamenting that the intense competition in the laser eye surgery business had "spawned advertising that trivializes the procedure."

"This is a real surgical procedure," he says in the interview, "people are being fooled into thinking it isn't." Little imagination is necessary to see

why, but the piety seemed a bit out of place given his contributions to the misperception.

In fairness to the surgeon, his colleagues are doing the same. Scanning my impromptu collection of dozens of LASIK advertisements from the last eight years, a May 2003 ad had similar "$100 off per eye" coupons, another suggested LASIK would allow one to "live life to the fullest," and many implied or said outright it would eliminate the need for glasses. Not a single ad said that LASIK was surgery.

Most people are aware that surgery has risks, but until these prospective patients get into the doctor's office, no one mentions that this is surgery. If LASIK is not regarded as a surgical operation, is it any surprise that many malpractice plaintiffs sue because they experience known complications of the procedure that were disclosed to them in the consent form?

The effect of having the advertising industry so heavily involved is that LASIK has become a commodity, not a surgery. Ad execs sell products or procedures, not surgeries, because surgery has a negative connotation that won't get people in the door.

Consequently, when patients come into your office, they have a preconceived attitude toward LASIK that is at odds with the undeniable fact that some people will end up with worse vision after the surgery than before, and many more will have low-light vision complaints they did not anticipate. Ads do not tell patients about the complications of LASIK. Can you educate a patient about risks in a short meeting when they have been exposed to months, if not years, of one-sided information?

Start by being honest. LASIK is surgery. Call it that, whether in your advertising, your phone directory listing, or the examining room. It has risks. Be upfront about it with LASIK candidates. The patient who decides not to have the surgery because of risks you disclosed is the same patient that would sue if you glossed over the complications or side effects and their result was imperfect.

Discuss risks and side effects in words patients will understand. The next time you go shopping, ask 10 people " customers, sales clerks, cashiers " what the word "presbyopia" means. Then ask yourself why you use it in the informed consent process. Tell your patients they'll need reading glasses if the surgery is successful. That will mean something to them. The same goes with "irregular astigmatism" or "endophthalmitis." And be careful with engineers. A disproportionate number of them seem to be plaintiffs.

Also be careful about offering a guarantee. Most people think that, if something is guaranteed, it will work, they'll get another one in exchange, or they'll get their money back so they can buy another one. Depending on circumstances, it may be something that is "reasonably implied" by the offer of a guarantee. (The Federal Trade Commission will hold you to not only what is explicitly said in your advertising, but also what is reasonably implied from the words used.)

A refund of the purchase price of a broken color television probably will satisfy the purchaser. Refunding surgical fees to a contact-intolerant patient with BCVA of 20/40-2 from irregular astigmatism probably will not. And do not count on wavefront custom ablation to bail you out of a bad result. For some reason, it does not seem to work as well on plaintiffs in litigation as it does on everyone else.

The routine

Automation was the promise of the mid-20th century that would free us from tedium and drudgery. Automatic icemakers, automatic washing machines, automatic transmissions. No need to think, just press a button and go. Routines are sometimes a form of automation, a way to process

something without giving it much thought.
But just as you still pay attention to the road after shifting your BMW into drive, you must pay attention to your patients' care regardless of the degree to which routines run your office.
This is as much a problem with staff as it is with the surgeon. Too many optometrists (that will probably not be named as defendants in lawsuits) have incorrectly assumed that a complaint of pain wasn't infection, that striae would heal on its own, and that the edge lift was not from epithelial ingrowth.
Or they may unquestioningly accept the information from a machine, without checking its accuracy. One cataract surgery claim arose from an A-scan machine in which the technician had inadvertently changed a "constant" when inputting the patient's "variables." The surgeon now confirms the constants with every reading.
I have many times heard refractive surgeons tell patients, either in writing or orally, that if the LASIK procedure doesn't work the first time, the patient can get a "touch-up." Again, the word "surgery" is avoided, and the patient may be left with the impression that 20/20 will be the ultimate result every time, but it may take a "touch-up" to get there.
The confidence that begets this comforting reassurance comes from the routine of successful results. But touch-ups, or more accurately re-operations, are unlikely to help the aberrant patient with decreased acuity from irregular astigmatism, or keratectasia. Again, these nonroutine occurrences are rare, but they do exist, and the patient needs to be informed about them, not led down a primrose path.
Another problem I have seen in business models that rely heavily on co-management of refractive patients is the tendency for the optometrist or nonoperating ophthalmologist to treat incipient complications too lightly. I suspect this may be due to reluctance to upset the routine of postoperative care.
Many problems, such as epithelial ingrowth, striae and infection, can be treated with a high probability of success if addressed quickly. If the problem is left to ferment, a good result may be delayed, more difficult to achieve, or may elude the surgeon entirely.
Similarly, if the surgeon is aware of an intraoperative complication, if at all possible she is the best person to see the patient postoperatively, because she knows exactly what went wrong. Unfortunately, many times the patient is "slotted" into the normal post-op track and is seen by someone unfamiliar with the complication. I see this most often with flap complications (free cap), or epithelial defects.
In one case, the optometrist who examined the patient postop did not see the note in the chart that a bandage contact lens was placed due to an epithelial defect, and did not see the lens when examining the patient's eye. The lens stayed in place, unknown to the patient, until the two-week visit. Fortunately, there was only edema, and no infection, but the patient alleged in the lawsuit that the edema led to striae, which resulted in decreased BCVA.
Resist the temptation to assume that problems will resolve with normal post-operative care. If it isn't routine, don't treat it like it is. Even if you do not plan to intervene surgically, at least watch the problem closely, with your own eyes. Take the extra time with the patient to ensure a good result. The patient will appreciate the extra attention, will have a better chance at a good outcome, and ultimately will be more likely to refer you to other patients. People remember those that help them when they're in trouble.

Unmet or unaddressed expectations

The best way to deal with a patient's complaint about an unexpected

complication is to make sure it is not unexpected. If a patient has been told he or she can expect to have dry eyes after LASIK, then they do not get upset when they experience this side effect. Same with side effects like edema or halos. Tell what they will see, and that they'll probably go away with time. If that is what they expect, they are more likely to experience it.

The power of suggestion is powerful with something as subjective as vision. If patients are surprised by a side effect, they may do as one plaintiff did " lie in bed and stare around the room every morning, shutting one eye and then the other, to see just how much his vision was deteriorating. He was an engineer, by the way.

Sometimes, a complication occurs that cannot be fixed right away, and may require tincture of time to improve or resolve. If this happens to your patient, don't turn your back on them. When taking the patient's deposition in a lawsuit, I often hear that the reason they brought suit is because "I just want to know what happened."

They complain that the surgeon never sat down with them to explain why they were not seeing well, what their options were, and the time delays they could expect before things got better. They complain that the staff seemed unsympathetic and afraid to talk to them candidly. From this position of frustration they went first to another ophthalmologist and then to an attorney.

To avoid this, remember the Golden Rule and put yourself in the patients' shoes. They are scared. They went in expecting a great result so they wouldn't need glasses anymore, as did you. They ended up, however with worse vision, even with their glasses.

What they need now is attention. They need you to sit with them, and explain carefully and honestly exactly why things turned out the way they did. (Don't admit fault or liability, however, without first contacting your insurance carrier.) My jurisdiction (Colorado) recently enacted legislation that permits a physician to apologize and express regret without that being admitted at trial if a lawsuit ensues.

If you can do so safely, tell them you're sorry about how things turned out. Tell them what you can and cannot do to help them. Tell them what to expect. And tell the billing department what has happened. I have had two lawsuits in the last year that started when a patient's account was turned over to a collection agency. If the patient is having trouble reading the dunning letter for the final payment on their LASIK surgery because their vision is impaired, they are likely to be upset. Finally, be nice. It goes a long way.

Nothing's perfect

LASIK is a great procedure, but it isn't perfect. Even assuming a complication rate of half of 1%, that's still five potential litigants per 1,000 operations. And considering the verdicts in some cases (e.g. Post v. University Physicians, Inc.) and the complaints I've seen in many others, a verifiable complication is not a requisite for a lawsuit.

This is an elective procedure. People pay for it because they think it will improve their lives. They think with LASIK they will be more active, more desirable. If their vision is no better after the surgery than before, they have wasted thousands of dollars (ads for $299 LASIK notwithstanding). If their vision is worse after the procedure " something blandly described as "losing a line or two of BCVA" " then they have potentially lost hundreds of thousands of dollars in income potential, depending on the severity of their impairment and the importance of vision to their job. And I am yet to meet a plaintiff for whom perfect vision is not required for employment and a life free of unbearable anxiety.

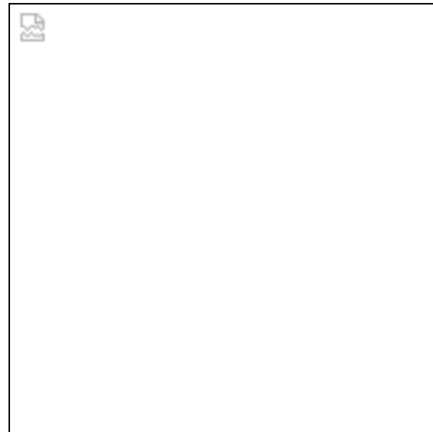
Selling LASIK to patients by dressing it up as something it's not will not do much good in the long run. Careful attention to education, expectations, and examination preoperatively, as well as attentive follow-up and some handholding postoperatively will improve your patient's satisfaction, increase your referrals, and decrease the risk of getting sued.

Contact Information
C. Gregory Tiemeier, Esq., has lectured at the ASCRSÃ¢?Â¢ASOA Symposium & Congress on risk management. He is a defense attorney who specializes in ophthalmic medical malpractice cases, and is a partner in the Denver law firm of Tiemeier & Hensen P.C. He represents physicians and other healthcare providers in professional liability litigation. Contact him at 877-868-4203, gtiemeier@thlaw.net

Exercising before surgery may aid recovery

by Matt Young EyeWorld Staff Writer

Those that expect surgery may like to know that exercising beforehand could aid recovery.



In a recent study on young and old rats, researchers found that those that exercised before simulated periods of bed rest recovered quicker than those that did not, according to lead study investigator Marybeth Brown, Ph.D., associate professor of physical therapy, University of Missouri-Columbia School of Health Professions.

Harnesses were strapped onto the rats so that weight was taken off their back legs to produce simulated bed rest. Brown determined that the rats that did not exercise beforehand lost the most muscle mass.

The rats were not entirely immobilized " they could still move although the weight was taken off their legs. Similarly, people in bed can move their legs " there's just no weight on them, she said.

Every rat still gained their pre-study mobility, although it took those that did not exercise longer than others.

Brown performed the study, in part, to help persuade insurance companies to cover "prehabilitation" programs.

The rats still underwent rehabilitation to recover.

Editors' note: Brown has no financial interest related to products used in her study.

Contact information
Brown: 573-884-7531, brownmb@health.missouri.edu