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Ask the Ethicist- Wrong Power IOL
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Q: During a routine cataract surgery postoperative visit, my patient expressed concern about suboptimal visual acuity. I discovered that a wrong-power IOL was used in the patient's surgery. This error occurred during surgery prep; the correct IOL power was noted in the patient's preoperative notes. How should I inform my patient that the wrong lens was used without losing her trust in my abilities or bringing on potential litigation?

A: Experts agree that if the wrong IOL is placed, ophthalmologists should tell patients the truth promptly in a detailed, open discussion and give an apology. Patients should actively participate in the discussion about methods to resolve the problem. Open and honest communication engenders trust, and including the patient in the resolution process strengthens that trust. The ophthalmologist should also waive any fees associated with replacing the lens.

Few medical errors have received as much attention as wrong-site surgery, which, in ophthalmology, includes wrong IOL power. The Ophthalmic Mutual Insurance Company has reported that the majority of wrong-site allegations—those considered completely preventable by juries and plaintiff attorneys—involved claims of wrong-power IOLs. The best cure for mistakes is prevention. Preoperative verification processes such as marking the eye and a presurgery time-out are recommended to prevent site errors and are standard in the profession. It is important to include a step in your time-out procedure to verify the IOL power to be used.

Common reasons for using the wrong IOL power include patients being out of order in the surgical queue, changing the IOL power intraoperatively, documentation errors, patients with the same last name having surgery on the same day and inputting incorrect data into the IOL calculators.

Claims experience has shown that a good physician-patient relationship depends on compassionate, timely and factual communication. When these components are missing and the patient is informed that they may be at risk for other problems, patients lose faith in their surgeons and often seek a second opinion or legal advice.

For more information or to submit a question for this column, contact the Ethics Committee staff at ethics@aao.org.