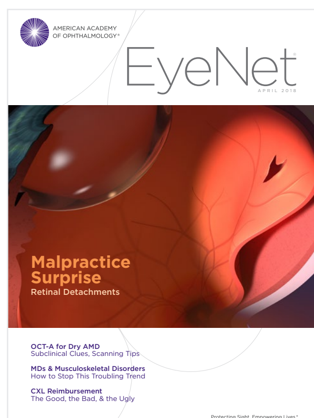
Letters



Scleral Depression: Clarifying Standards of Care

We read with interest the article "Malpractice Risk: Retinal Detachments" (Feature, April). In this article, the "standard of care" is discussed for patients at risk for retinal detachment (RD). The standard of care is a legal term, not a medical term, and accordingly has a legal definition ("what a similarly trained practitioner would do under similar circumstances"). This is used as a sort of bottom line conclusion by an expert to characterize the appropriateness of clinical care delivered in a specific setting. While that characterization of appropriate medical care should ideally be supported by evidence-based data, it often represents an extrapolation from the best available data which may be incomplete or not ideally suited to the question at hand. Indeed, there may be more than one unique standard of care in a situation.

We appreciate the importance of timely diagnosis of retinal breaks and RDs, and we recognize the value of scleral depression in selected patients in selected circumstances. However, peer-reviewed evidence is limited specifically regarding the use of scleral depression during indirect ophthalmoscopy. The classic description of scleral depression was published by Brockhurst in 1956[1] without comparative data. In contrast, the authors of a prospective study of 50 patients (100 eyes) with retinal breaks published in 2015 concluded: "We found that an examination using a [28-D] lens with scleral depression did not provide any additional benefit to an examination without depression during indirect ophthalmoscopy."[2]

WRITE TO US. Send your letters of 150 words or fewer to us at *EyeNet Magazine,* American Academy of Ophthalmology, 655 Beach Street, San Francisco, CA 94109; e-mail eyenet@aao.org; or fax 415-561-8575. (*EyeNet Magazine* reserves the right to edit letters.)

In the *EyeNet* article, Dr. George Williams cited the Academy's *Preferred Practice Pattern* (*PPP*) on the topic and said, "As [the *PPP*] states, the standard of care for any at-risk patient requires a dilated examination of the entire fundus with indirect ophthalmoscopy and scleral depression—period, end of discussion." In our opinion, this statement requires further discussion and clarification. A literal, noncontextual reading of this statement may create unwanted and unnecessary litigation risks for ophthalmologists who practice appropriate medical care but elect to not use scleral depression. Many patients are intolerant of scleral depression, and others may have a widely dilated pupil allowing an excellent view of the retinal periphery without scleral depression. We further note that the *PPP* specifically states, "*Preferred Practice Patterns* guidelines are not medical standards to be adhered to in all individual situations."[3]

If there were adequate peer-reviewed evidence to support the need for scleral depression in every at-risk patient, rather than opinions carried forth from older literature, then there would be uniform agreement regarding the standard of care.

Stephen G. Schwartz, MD, MBA
Thomas A. Albini, MD
Audina M. Berrocal, MD
Harry W. Flynn Jr., MD
Jaclyn L. Kovach, MD
William E. Smiddy, MD
Jayanth Sridhar, MD
Justin H. Townsend, MD
Bascom Palmer Eye Institute, Miami

1 Brockhurst RJ. *Am J Ophthalmol.* 1956;41(2):265-272.
2 Shukla SY et al. *Ophthalmology.* 2015;122(11):2360-2361.
3 American Academy of Ophthalmology Retina/Vitreous Panel. *Preferred Practice Pattern. Posterior Vitreous Detachment, Retinal Breaks, and Lattice Degeneration.* San Francisco, Calif: American Academy of Ophthalmology; 2014. Available at: aao.org/ppp.

A Response From Dr. Williams

The authors raise valid and important issues concerning my use of the term standard of care. I concur that my statements create confusion between what I consider to be a preferred practice as defined in the Academy's *PPP* and the legal implications of the concept of standard of care. I agree that, while scleral depression can definitely help detect retinal tears, there are clinical scenarios in which indirect ophthalmoscopy with scleral depression is not possible or necessary. As the Chair of the Board of Directors of the Ophthalmic Mutual Insurance Company (OMIC), I apologize for this error.

Several facts are worth remembering, however. First, missed RDs can lead to severe loss of vision. Second, missed RDs are a not uncommon cause of claims in ophthalmology. (As noted in the article, a recent OMIC analysis of diagnostic errors leading to malpractice claims found the most frequently missed diagnosis was retinal detachment.) Third, patients with the sudden onset of flashes and floaters with

Florida Medical Association
& Sarasota Retina Institute
The 33rd Annual mid-winter
Sarasota Vitreo-Retinal Update Course
Save the Dates

February 14th, 15th & 16th, 2019

Ritz-Carlton
Sarasota, FL

For further information contact:

Kathy Johnson
Sarasota Retina Institute
3400 Bee Ridge Rd.,
Suite 200
Sarasota, FL 34239
(941) 921-5335 ext. 229
SRIKathy@hotmail.com

The activity has been approved for *AMA PRA Category 1 credit*™

AMERICAN ACADEMY
OF OPHTHALMOLOGY®

EyeNet
Gives You
the Full Picture

Poll-topping, digestible coverage of all things ophthalmologic

Visit Us Online
aao.org/eyenet

Write to Us
eyenet@aao.org

Protecting Sight. Empowering Lives.®

pigmented cells or blood in the vitreous are at an increased risk of having a retinal tear. A careful—and documented—examination of the peripheral retina is of paramount importance. In such circumstances, performance of scleral depression may offer diagnostic advantage.

At OMIC, we consider every malpractice claim as an opportunity to improve patient care through analysis of the events leading to the claim. More often than not, our expert review indicates that there is no evidence of malpractice. We vigorously defend such claims and typically are successful. Unfortunately, there are claims for which expert review indicates that defense will very likely be unsuccessful. Lessons learned from these cases inform risk management with the twin goals of improved patient care and diminished liability. Although that message was the intent of the article on diagnostic errors related to retinal detachment, it was lost in my poor choice of words.

I thank my colleagues for their thoughtful comments in the spirit of our mission of protecting sight and empowering lives.

George A. Williams, MD
Royal Oak, Mich.

Regarding Unverifiable Publications on Residency Applications

Tamez et al., in their report as summarized in this issue (Journal Highlights, page 22), discovered a 9.2% incidence of unverifiable publication in SF Match applications when any publications were listed. The authors suggested that the SF Match process could be improved to ensure a more accurate application process and to maintain high ethical standards of the applicants.

The Association of University Professors of Ophthalmology (AUPO) oversees the SF Match. As Executive Vice President of AUPO, I certainly concur with this assessment as a prelude to guaranteeing a fair selection process for the applicants and reducing the surveillance burden of training programs.

While some misrepresentations may be intentional, others may result from naiveté or from carelessness. As a method of addressing the latter, including instructions to the applicant defining peer-reviewed versus non–peer-reviewed articles—with a warning that citations are subject to verification—might be a first step. This also could be accompanied by a clarification for the candidate, noting that unverifiable research publications may result in adverse consequences, including disqualification from the SF Match. In the future, SF Match data processing capabilities may be able to provide full surveillance enhancements that would automatically pick up inaccuracies in each applicant's reporting of research publications.

Steven E. Feldon, MD, MBA
Rochester, N.Y.

MORE ONLINE. For an additional letter on RDs, see this issue at aao.org/eyenet.