

Policy Statement

An Ophthalmologist's Duties Concerning Postoperative Care

Policy

It is the position of the American Academy of Ophthalmology that an operating ophthalmologist's duties to a patient with respect to postoperative medical care are satisfied only if the ophthalmologist:

- a. Performs the patient's postoperative medical care throughout the patient's "at-risk" postoperative period; or
- b. Arranges for the aspects of the patient's postoperative medical care not performed by the operating ophthalmologist to be provided throughout the patient's at risk period by someone who is competent and willing to provide that care (and is properly licensed to do so within the state in which the care is being provided), with the consent, in advance of surgery, of both the patient and the person selected to provide that care.¹

Background

The court decision in **Bateman v. Rosenberg** clarifies the responsibilities of the ophthalmologist in providing postoperative care to the patient. See generally **Bateman v. Rosenberg**, 525 S.W. 2d 753 (Mo. Ct. App. 1975)

"The surgeon's obligation to the patient is not discharged with the conclusion of a successful operation. Unless terminated by the parties, his relationship to the patient `...continues until ended by...the cessation of the necessity which gave rise to the relation, and the surgeon must not only use reasonable and ordinary care and skill in performing the operation, but during the continuance of the relation of physician and patient exercise ordinary diligence in the subsequent treatment and give, or see that the patient is given, such attention as the necessity of the case demands.' Where the doctor knows or should know that a condition exists which requires continuous or frequent expert attention to prevent injurious consequences he must render that attention or see that some other competent person does so."

Bateman v. Rosenberg, 525 S.W.2d at 756 (quoting **Reed v. Laughlin**, 58 S.W.2d 440 (Mo. 1933)).

If an ophthalmologist does not intend to provide postoperative medical eye care, this fact is one that a reasonable patient would consider to be material in deciding whether to undergo the proposed surgery by that ophthalmologist, and should be disclosed sufficiently in advance of the surgery. Also, a patient would expect to be informed whether and in what ways the risks and benefits of the proposed surgery, as well as the probability of success of the surgery, might be affected by the qualifications and competence of the person expected to provide postoperative care; particularly if that person does not have the ophthalmologist's specialized education, training, experience and ability to promptly recognize and effectively manage postoperative complications. The informed consent process should therefore disclose how delegation of care to another individual affects risks.

Guidelines

The ophthalmologist is uniquely competent and qualified to perform ophthalmic surgery with its pretreatment evaluation and postoperative management. The operating surgeon has primary responsibility for the quality of all aspects of this care, including those which he or she may delegate or refer to others. State boards of medical examiners and professional review organizations are encouraged to develop appropriate guidelines consistent with the standard of care for surgery and post-surgical management in the respective state.

In all cases, of course, the law imposes special obligations on the operating ophthalmologist who does not provide postoperative medical care. If these obligations are not met, the ophthalmologist risks liability for patient injury, including injury resulting from the acts or omissions of others to whom the provision of postoperative care is inappropriately delegated, or for inadequate patient informed consent, or both.

In general, a physician's failure to provide postoperative medical care may be considered "abandonment" of the patient at the operating room door. This is the effect of the ophthalmologist's failure to provide, or make reasonable arrangements for the competent provision of, postoperative medical care throughout the patient's episode of illness.

The law concerning patient abandonment is clear. Once a physician-patient relationship is established, and the patient is in need of medical treatment, the physician may cease treatment before termination of the patient's episode of illness only in certain circumstances. See D. Louisell & H. Williams, *Medical Malpractice* ¶ 8.08 (1985); 70 C.J.S. *Physicians, Surgeons, and Other Health-Care Providers* § 98 (2005); 61 Am.Jur.2d *Physicians, Surgeons, and Other Healers* § 218 (2005). One of those circumstances is an appropriate withdrawal from treatment by the physician. The courts hold that a physician may appropriately discontinue treatment of a patient only if the physician provides reasonable notice to the patient (if the discontinuance is foreseeable) and, unless the patient directs otherwise, provides suitable arrangements for continued care and treatment by another person competent to provide that care and treatment. *Katsetos v. Nolan*, 368 A.2d 172,182 (Conn. 1976). See also *Current Opinions of the Judicial Council of the American Medical Association*, § E-8.115 "Termination of the Physician Patient Relationship" (requiring that notice of a physician's withdrawal be given "sufficiently long in advance of withdrawal to permit another medical attendant to be secured"). Courts also require that the successor to or substitute for the initial physician be qualified to provide the necessary care, and that the initial physician exercise due care in the choice of his or her successor or substitute. See *Rise v. United States*, 630 F.2d 1068, 1072 (5th Cir.1980) (physician can be held negligent for referring a patient he knows to be in need of a particular type of care to a physician who cannot provide it); *Bateman v. Rosenberg*, 525 S.W.2d at 756 (if a surgeon is unable to personally attend to a patient following an operation, it is incumbent upon him to see that those persons providing care are competent to perform those services); *S.R. v. City of Fairmont*, 280 S.E.2d 712, 716 (W. Va. 1981) (court found that clinic's failure to arrange for appropriate post-operative care was the cause of plaintiff's ultimate harm); *Sturm v. Green*, 398 P.2d 799, 804 (Okla. 1965) (general rule is that a physician who is unable to care for a patient may send a substitute to care for the patient, and no liability attaches for negligence of the substitute absent agency or negligence in selection of the substitute).

The issue of postoperative care in the context of the Medicare program has been considered by a federal district court in *Greene v. Bowen*, 639 F. Supp. 554 (E.D. Cal. 1986). The Department of Health and Human Services determined that a surgeon should be excluded from the Medicare program for committing "gross and flagrant violations" of his duties to Medicare patients by failing to provide their postoperative care and by leaving that task to the local referring physicians. On the basis of that determination, HHS notified the surgeon

that pending an administrative hearing, he would be excluded from participation in the Medicare program, and notice of that exclusion would be published.

The surgeon sought a court order to enjoin HHS from excluding him from the Medicare program and from publishing notice of his exclusion until the conclusion of that hearing. The court concluded "that an injunction could and should be framed in such a manner as to require the doctor to personally provide postoperative care to patients upon whom he has operated, and that, as so drawn, an injunction will limit any hardship to the government and serve the public interest." Accordingly, the court issued an order granting the injunction, "provided that the plaintiff shall not perform any surgery upon any patient under circumstances in which he cannot personally provide postoperative care."

It is well settled law that ophthalmologists must obtain a patient's informed consent before performing medical or surgical procedures. The courts hold that whether or not a patient's consent is "informed" depends upon the adequacy of the disclosures made to the patient before treatment. Although the precise rules vary somewhat among the states, in general, the courts require physicians to disclose the factors that a reasonable patient would consider to be material in deciding whether or not to undergo the proposed treatment. In broad terms, these disclosures include the diagnosis; the nature, purpose, risks, benefits, and probability of success of the proposed treatment and of each alternative treatment; and the risks and benefits of no treatment. See D. Louisell & H. Williams, *Medical Malpractice* ¶ 22.01 (1985).

Approved by:	Board of Directors, September 1987
Revised and Approved by:	Board of Directors, June 1992
Revised and Approved by:	Board of Trustees, September 1998
Revised and Approved by:	Board of Trustees, February 2003
Revised and Approved by:	Board of Trustees, December 2006