SUNCOAST SEMINAR

Presented by the
Pinellas Optometric Association

Course Syllabus

Suncoast Seminar 2024
Schedule of Events

Saturday, April 27, 2024

7:45 am – 8:15 am	**Registration** **Continental Breakfast** - *sponsored by Eye Institute of West Florida* **Exhibit Hall** open
8:15 am – 9:55 am	**Co-Managing the Light Adjustable Lens (90938-PO)** T. Hunter Newsom, M.D., Brian Szabo, D.O., and Eric Fazio, O.D.
9:55 am – 10:40 am	**Break** - *sponsored by Updegraff Vision* **Exhibit Hall** open
10:40 am – 12:20 pm	**Emerging Trends in Macular Disease (TQ) (90790-TD)** Sherrol A. Reynolds, O.D.
12:20 pm – 1:10 pm	**Lunch** - s*ponsored by St. Luke's Cataract & Laser Institute* **Exhibit Hall** open
1:10 pm – 1:20 pm	**Lighthouse of Pinellas Update**
1:20 pm – 1:30 pm	**F.O.A. Update**
1:30 pm – 3:10 pm	**Eye on Systemic Disease (TQ) (90791-SD)** Sherrol A. Reynolds, O.D.
3:10 pm – 3:30 pm	**Break -** *sponsored by Sight360*
3:30 pm – 5:10 pm	**The ODs Role in Diabetes (TQ) (86739-TD)** Sherrol A. Reynolds, O.D.

Sunday, April 28, 2024

7:30 am – 8:00 am	**Registration** **Continental *Breakfast*** - *sponsored by Next Vision Instruments*
8:00 am – 9:40 am	**Neural Pearls (TQ) (89379-NO)** Joe Sowka, O.D.
9:40 am – 10:00 am	**Break** – *sponsored by Suncoast Seminar*
10:00am – 11:40 am	**Prevention of Medical Errors (89825-EJ)** Joe Sowka, O.D.
11:40 am – 12:00 pm	**Break** – *sponsored by Suncoast Seminar*
12:00 pm – 1:40 pm	**Florida Jurisprudence (89275-EJ)** Joe Sowka, O.D.

US EYE
BETTER TOGETHER

NEURAL PEARLS

Joseph Sowka, OD, FAAO, Diplomate
Center for Sight/ US EYE

COVD

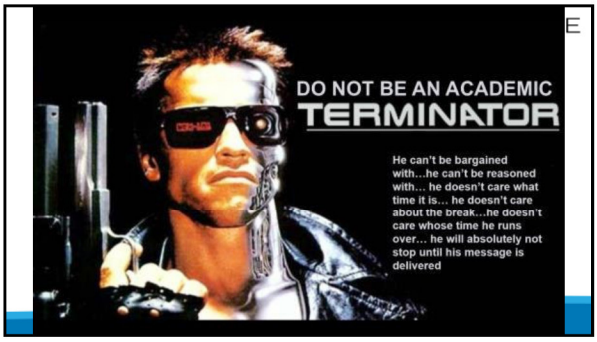
DISCLOSURE:

US EYE

Dr. Joseph Sowka is/ has been in the past 24 months a consultant or member of the advisory or speaker boards for B&L. All relevant relationships have been mitigated. Dr. Sowka has no direct financial interest in any of the diseases, products or instrumentation mentioned in this presentation.

He is a co-owner of Optometric Education Consultants. www.optometricedu.com

Optometric Education Consultants



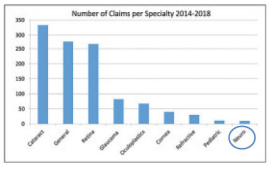
US EYE

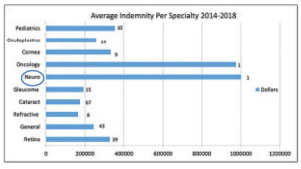
NEURO-OP IS A FINANCIALLY REWARDING SPECIALTY…

US EYE

NEURO-OP IS A FINANCIALLY REWARDING SPECIALTY…SAID NOBODY EVER

US EYE





Courtesy of Ophthalmic Mutual Insurance Company

US EYE

Neuro-Op

- High risk
- Is this urgent? Can it wait?
- Complicated
- Diagnose and Adios
- Schedule-busting

US EYE

Dr. Andy Lee

US EYE

KNOW WHAT CAN KILL, MAIM, AND BLIND IMMEDIATELY.

US EYE

ONCE YOU HAVE RULED OUT BAD STUFF, YOU HAVE TIME TO FIGURE THINGS OUT.

US EYE

ACUTE PAINFUL IS A NEURO-OPHTHALMIC EMERGENCY

US EYE

ACUTE PAINFUL *ANYTHING* IS A NEURO-OPHTHALMIC EMERGENCY

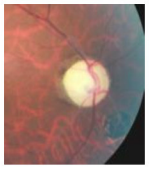
US EYE

URGENCY OF EVALUATION IS DICTATED BY DURATION OF CONDITION

US EYE

46 YOM

- Reports waking up 3 months ago not being able to see OD
- LP OD, 20/20 OS
- Disc pallor OD- no other concurrent findings
- Last medical exam unknown- no medical hx
- Resident gets nervous- sends to ER immediately
- How long do we have to get this worked up?



US EYE

ER PHYSICIAN ENCOUNTERING A PATIENT WITH AN EYE PROBLEM

US EYE

Neuro-ophthalmic Urgencies and Emergencies

- GCA
  - Any sudden vision loss in the elderly
- Pituitary apoplexy
  - Headache, field loss, diplopia
- Aneurysm
  - Pupils
- Papilledema
  - Clinical suspicion
- Carotid dissection
  - Horner syndrome

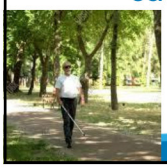
US EYE

66 YOF ESR = 96

- New onset sudden vision loss
  - VA: 20/400 (longstanding macular scar)
  - Noticed inferior vision loss x 1 day
  - Inferior arcuate scotoma
- OD disc edema- mild pallor, no hemorrhages or teliangectasia
- OS disc- small, crowded disc at risk; C/D < 0.2
- Mild headache- relieved by OTC
- Malaise and loss of appetite- lost 7 lbs over 4 weeks
- No jaw claudication or temporal head pain
- What to do?

US EYE

ANY ACUTE VISION LOSS IN THE ELDERLY IS GCA UNTIL PROVEN OTHERWISE



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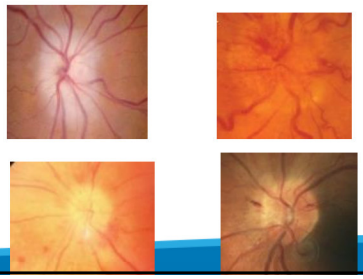
Anterior ISCHEMIC OPTIC NEUROPATHY

- Hypoperfusion of the posterior ciliary arterial supply to the anterior optic nerve head.
- May be arteritic (AAION) or non-arteritic (NAAION)
- Mechanical factors and atherosclerotic disease play a role in the non-arteritic form while vasculitis contributes in the arteritic form.
- Unilateral presentation but high incidence of subsequent contralateral involvement
  - AAION

US EYE

AAION VS NAAION



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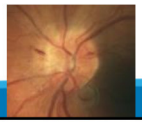
NAAION

- Risk factors:
  - Hypertension, diabetes, atherosclerotic disease, small optic nerves
- Inferior field defects
- Hyperemic swollen nerve- disc at risk
- Progressive moderate vision loss with potential recovery
- Late 30s/ early 40s and beyond
- Painless



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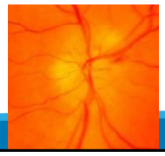
AAION

- Pallid optic nerve swelling with flame hemorrhages, arteriole attenuation and NFL infarcts
- Pain (of some sort)
- Severe optic nerve dysfunction
- Visual field defects
- Giant cell arteritis/ PMR- risk factors
- Typically 70s, uncommon under 60
  - Any patient over 50 is at risk
- High risk bilateral involvement



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Diagnosis

- Careful history: Must directly ask about nonvisual symptoms
  - Headache (present in over 90%), scalp tenderness, jaw claudication (almost diagnostic), ear pain, arthralgias, temple pain and/or tenderness, malaise, intermittent fevers
- Examination
- Laboratory studies
  - Erythrocyte sedimentation rate
    - Lowered by statins and NSAIDS
  - C-reactive protein
    - Not affected by statins and NSAIDS
  - Elevated platelet count

US EYE

Initial symptoms in GCA

- Headache
- PMR
- Hair, chair and stair (fair?)
  - One study: 84% White vs. 14% Black
  - Black patients had no elevated platelets where While patients did (0% vs 34%)
  - Black patients more likely have concurrent diabetes
- Fever
- Visual symptoms without vision loss
  - TIA, diplopia
- Weakness, malaise, fatigue
- What do all of these things have in common?

A normal exam

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Vision Loss and Ocular Findings in GCA

- AION
- CRAO
- PION
- TIA
- Transient diplopia

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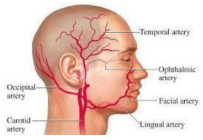
Headache and pain in GCA

- Temporal
- Occipital
- Neck
- Ear
- Jaw
- Scalp



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AAION

Diagnosis

- Prodrome, GCA symptoms
- Elevated ESR/CRP (combination of the two gives high specificity [97%])
- Elevated platelet count (acute phase reactant)
- Ophthalmoscopy
- Fluorescein angiography
- Temporal artery Biopsy
  - Negative biopsy: Read the report- "No giant cells, no active arteritis"
  - Focal interruption of the internal elastic lamina= healed arteritis
- Temporal artery ultrasound

Treatment

- Prompt steroids and hydration
- Consider IV when vision loss present
  - Very effective in prevention of second eye
  - Occasionally restores vision
  - Best done through ER
  - 250 mg solumedrol QID x 3 days followed by orals

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NAAION IS DIAGNOSED IN THE NEGATIVE. GET THE TESTS DONE PROMPTLY WITH AION

US EYE

REMEMBER THE E'S IN GCA:
ELDERLY, ESR IS ELEVATED, ONLY SEES THE BIG E ON THE EYE CHART, AND ITS AN EMERGENCY

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What to say to the ER doc

- Don't say, "*This patient has blurred vision*"

- Say, "*This elderly patient has suddenly lost vision in one eye and will go totally blind from giant cell arteritis if they aren't treated with steroids immediately!*"

US EYE

Neuro-ophthalmic Urgencies and Emergencies

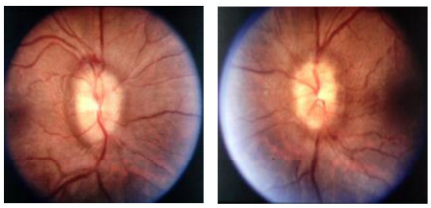
- GCA
  - Any sudden vision loss in the elderly
- Pituitary apoplexy
  - Headache, field loss, diplopia
- Aneurysm
  - Pupils
- Papilledema
  - Clinical suspicion
- Carotid dissection
  - Horner syndrome

US EYE

28 YOF

- Presents with intermittent blurred vision & visual "grey-outs", intermittent horizontal diplopia, and chronic headache steadily worsening X 2 weeks
- MHx: "white coat hypertension", shoulder injury X 6 mos
- Meds: Flexeril® 10 mg BID PRN
- Height / weight: 5'3", 220 lbs.
- VA: OD 20/20, OS 20/20
- Pupils & motility: normal

US EYE



What questions do you want to ask?
What tests do you want to perform?

US EYE

28 YOF

- Additional hx: Dull "ringing" in ears
- BP: 142/100
- SLE: unremarkable
- T_A: OU 16 mm Hg
- VF: blind spot enlargement & nasal step defect OU
- Serology Normal
- Imaging: small ventricles, otherwise normal
- LP: O.P. = 510 mm H_2O; all CSF studies normal
- DX: Pseudotumor cerebri (PTC)

US EYE

PAPILLEDEMA: Signs & Symptoms

- Signs:
  - bilateral disc edema
    - superior & inferior aspects of discs affected FIRST
    - obliteration of optic cup
    - hemorrhages common
    - absence of SVP
    - Paton's folds
  - highly variable VF defects
    - enlarged blind spot (early)
    - arcuate defects and constricted (late)
  - NO RAPD typically
  - VA near normal
- Symptoms:
  - Visual:
    - transient visual obscurations
    - intermittent horizontal diplopia
  - General:
    - headache common
    - nausea & vomiting
    - dizziness
    - tinnitus

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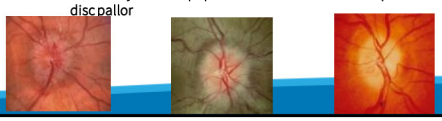
Papilledema Types:

- Acute
  - Hemorrhages, exudates, hyperemia, RNFL edema
- Chronic
  - Minimal hemorrhage/exudate. Collateral vessels may be present
- Atrophic
  - Eventually occurs If papilledema remains chronic. Optic disc pallor



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PAPILLEDEMA Pathophysiology

- Disc edema results from axoplasmic stasis
  - intracellular fluids, metabolic by-products accumulate and are regurgitated at the level of the optic nerve head
  - in papilledema, cerebral edema is effectively transmitted along the common meningeal sheaths of the brain and optic nerve producing an engorged, swollen disc.

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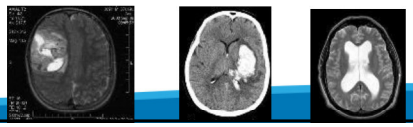
PAPILLEDEMA Pathophysiology

- Associated with intracranial abnormalities:
  - increased brain volume (intracranial mass lesion)
  - increased intracranial blood volume
    - Intracranial hemorrhage
  - increased CSF volume
    - Hydrocephalus
    - Ventricular blockage by mass lesion



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PAPILLEDEMA Management

- Rule out "swollen disc masqueraders"
  - ultrasonography can be invaluable in differentiating ONHD
  - also consider color, margins, SVP, vasculature, etc.
- Acute papilledema constitutes a medical emergency
  - Immediate neuro-imaging to rule out an intracranial mass.
  - If imaging is normal, lumbar puncture to measure CSF pressure and exclude meningitis or other disease processes is necessary.
- Atrophic papilledema with significant vision/field loss:
  - urgent measures must be undertaken to prevent blindness
- Papilledema accompanied by any neurologic abnormalities, fever or stiff neck:
  - Possible serious underlying neurologic abnormality, intracranial infection or bleed requiring immediate medical attention.

US EYE

PTC vs. IIH

- Pseudotumor Cerebri (PTC)
  - Increased intracranial pressure in the absence of an intracranial mass lesion
  - Many causative agents have been identified
- Idiopathic Intracranial Hypertension (IIH)
  - Increased intracranial pressure without an identifiable cause
  - Young, obese females are at risk
- Primary PTC
  - IIH
- Poor CFS drainage

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Pseudotumor

- Symptoms
  - Headache-84%
    - Increased ICP
  - TVO-68%
    - Vascular congestion and transient blood flow cessation
  - Back/radicular pain-53%
    - Increased CSF pressure within dural sheath
  - Pulsatile tinnitus-52%
    - Cerebral venous sinus stenosis
  - Diplopia-18%
    - CN 6 palsy

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Pseudotumor- medications

- Oral contraceptives
- Tetracyclines
- Acutane
- Vitamin A retinoids
- Estrogen
- Growth hormone
- Lithium
- Others
- All thought to decrease CSF resorption at arachnoid villa

Pseudotumor clues and concerns

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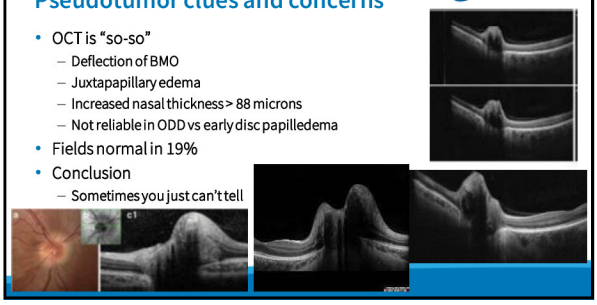
- OCT is "so-so"
  - Deflection of BMO
  - Juxtapapillary edema
  - Increased nasal thickness > 88 microns
  - Not reliable in ODD vs early disc papilledema
- Fields normal in 19%
- Conclusion
  - Sometimes you just can't tell



PSEUDOTUMOR CEREBRI DIAGNOSIS

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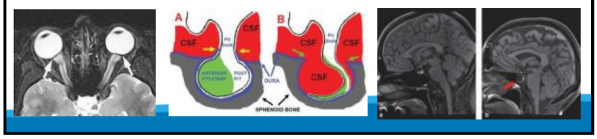
- Si/SX: consistent with increased ICP
- Papilledema
- Normal neurological examination
  - except for cranial nerve 6 abnormalities
- Neuro-imaging: Normal without evidence of hydrocephalus, mass, or structural lesion, thrombosis
- Normal CSF composition

Elevated LP opening pressure
- Adults: > 250 mm CSF
- Children: > 280 mm CSF
  > 250 mm CSF if not sedated/obese

PSEUDOTUMOR CEREBRI DIAGNOSIS

US EYE

- LP may be deferred if:
- MRI/MRV shows no additional abnormalities and has characteristic findings of flattened globe and empty sella.
- No evidence of fever or acute infection
- Typical profile



PSEUDOTUMOR CEREBRI MANAGEMENT

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- No visual loss
  - Symptomatic headache therapy
  - Acetazolamide 500 mg tid
  - Weight reduction
- Mild visual loss
  - Acetazolamide 500 mg tid
    - Furosemide, Topiramate, Zonisamide
  - Weight reduction

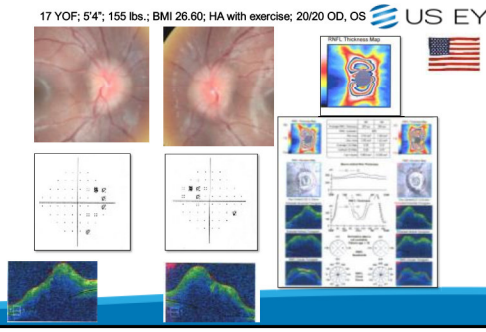
PSEUDOTUMOR CEREBRI MANAGEMENT

US EYE

- No/ Mild visual loss
  - Prognosis
    - Excellent (all signs and symptoms, visual loss)
    - 6-9 months
  - Follow-up and visual fields
- Role of weight loss
  - Treat the primary problem
    - 10% weight loss
  - Prevent recurrence
    - Keep the weight down

17 YOF; 5'4"; 155 lbs.; BMI 26.60; HA with exercise; 20/20 OD, OS

US EYE



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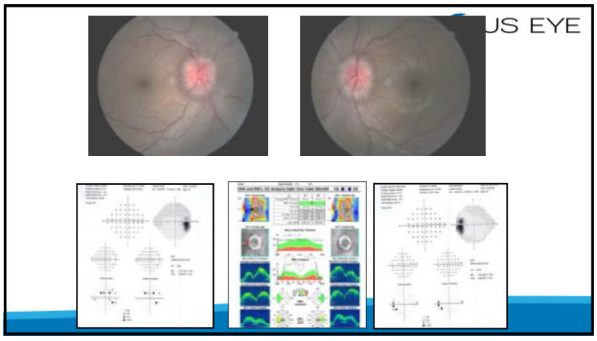
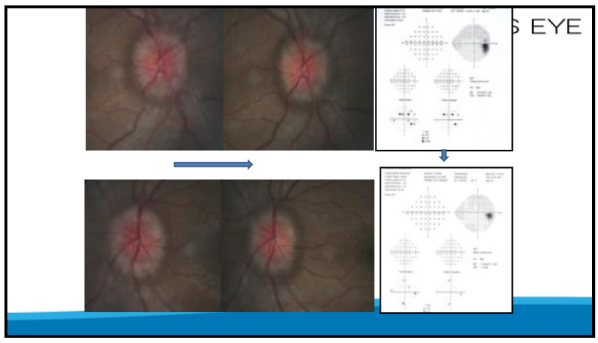
33 YOF

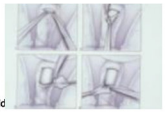
- Horizontal diplopia
- Headache
- TVOs 20/day
- Denies OCP, tetracyclines, vitamin A
- Lost 10 lbs- headaches improved
- 118/72
- 5'5"; 160lbs; BMI 26.62

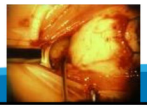




PSEUDOTUMOR CEREBRI MANAGEMENT

- Severe, or progression of visual loss or medically refractive
  - Optic nerve sheath decompression (ONSD)
  - High-dose IV steroids and acetazolamide
  - Lumboperitoneal shunt
    - Failed ONSD, Declined ONSD, Intractable headache
  - Venous sinus stenting
    - Venous sinus stenosis at the junction of the transverse and sigmoid sinus
    - Intrinsic (cause) does not does not reverse with normalization of intracranial pressure
    - Extrinsic type (result) does.





IIH IS A SLOWLY PROGRESSIVE CONDITION…UNTIL ITS NOT

Fulminant IIH

- Same diagnostic criteria for IIH/PTC
- Less than 4 weeks between symptoms and loss of field/acuity
- Vision worsening rapidly over several days
- Typically needs CSF diversion surgery and/or ONS fenestration

US EYE

A Different Patient and Different Approach

- 32 YOF
- Chronic headaches x 2-3 months
- Has gained weight in past several months
  - Had gained 40-50 lbs in past 2 years overall
- Referred in for suspected disc edema
- Denies oral contraceptives, tetracycline use, vitamin A use
  - Iron tablet and vitamin B9
- Bilateral TVO in past 1-2 mos
  - Several seconds to 1 minute; 2-3/day
- BVA 20/15 OD, OS; PERRL(-) RAPD

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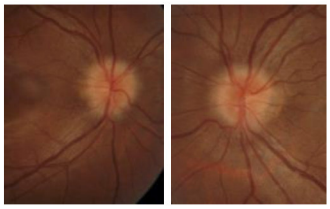

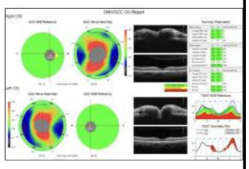

Fields deemed unreliable due to dilation, fatigue, anxiety- she didn't feel that she was with the test

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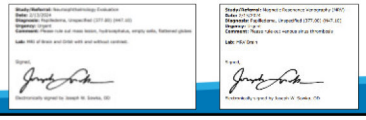
- Chronic in appearance
  - No hemorrhage or exudation
  - Possibly 2 years in development; 2-3 months with symptoms
- OCT shows no discernible GCC loss
  - RNFL assessment dodgy due to edema
- Outpatient management- informed PCP



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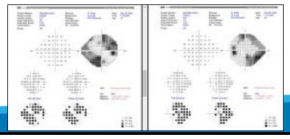
- Insured but significant deductible
  - Patient wants to find imaging center for payment plan
  - Obtains 2 appointments but cancels for financial reasons
  - PCP tries to help- recommends health centers for uninsured/ underinsured
    - Need to apply, get approved, go through foundations, etc.
- 2 week f/u- disc photos and acuity unchanged- fields repeated



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Neuro-ophthalmic Urgencies and Emergencies

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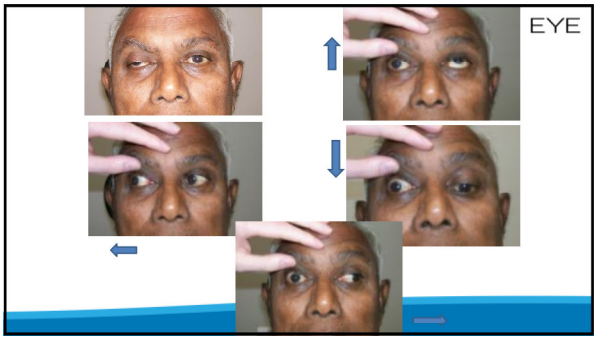
  - Clinical suspicion
- Carotid dissection
  - Horner syndrome

US EYE

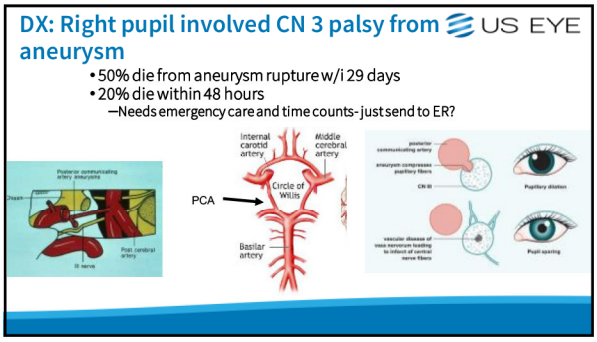
63 YOIM

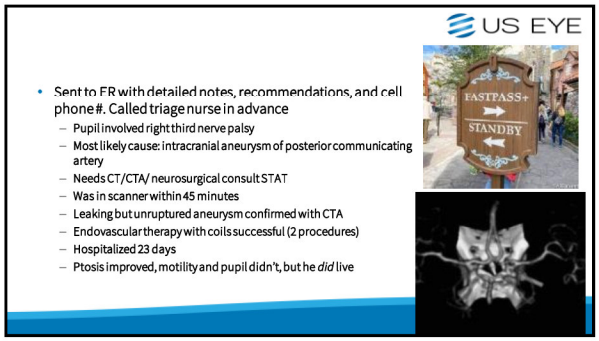
- Long standing glaucoma patient
- Sudden onset of orbital pain x 3 days
- + DM; +HTN
- On coumadin
- Pacemaker
- No vision change
- Presents as walk-in emergency glaucoma eval

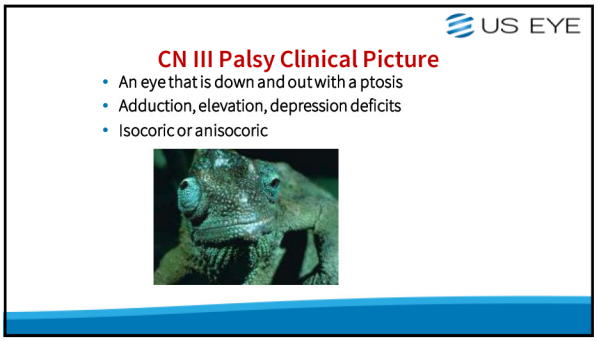

US EYE


EYE


EYE
5 mm
unresponsive
2 mm
responsive

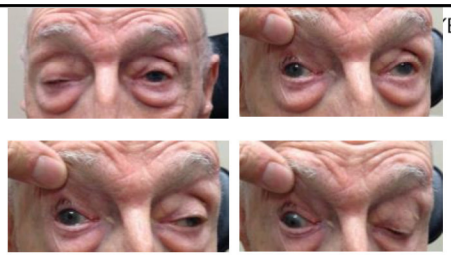

DX: Right pupil involved CN 3 palsy from aneurysm
US EYE
• 50% die from aneurysm rupture w/i 29 days
• 20% die within 48 hours
—Needs emergency care and time counts- just send to ER?
Internal carotid artery
Middle cerebral artery
PCA
Circle of Willis
Basilar artery


US EYE
• Sent to ER with detailed notes, recommendations, and cell phone #. Called triage nurse in advance
– Pupil involved right third nerve palsy
– Most likely cause: intracranial aneurysm of posterior communicating artery
– Needs CT/CTA/ neurosurgical consult STAT
– Was in scanner within 45 minutes
– Leaking but unruptured aneurysm confirmed with CTA
– Endovascular therapy with coils successful (2 procedures)
– Hospitalized 23 days
– Ptosis improved, motility and pupil didn't, but he *did* live
FASTPASS+
STANDBY


US EYE
CN III Palsy Clinical Picture
• An eye that is down and out with a ptosis
• Adduction, elevation, depression deficits
• Isocoric or anisocoric

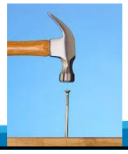
83 YOM

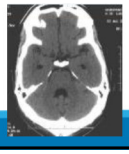
- Diabetic; LBS in 300s;
- A1C around 11
- Pupils normal MRI ordered through PCP
- Indication for imaging: *Brain ischemia*
- What 2 errors were made here?



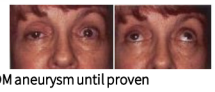
US EYE

THE WORLD'S BEST NEURORADIOLOGIST CAN'T HELP YOU IF YOU DON'T ORDER THE SCAN, ORDER THE RIGHT SCAN, AND TELL THEM WHAT TO LOOK FOR.





Still More Clues



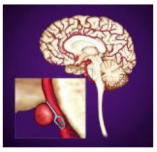
- Pupil involved CN III palsy is PCOM aneurysm until proven otherwise
- Incomplete palsy is PCOM aneurysm until proven otherwise
  - Regardless of pupil
- 30% of CN III palsy are caused by aneurysm
- Pain is pain
  - Only helpful when not present
- Vasculopathic CN III will resolve in time
- Life threatening posterior communicating aneurysm will rupture in time

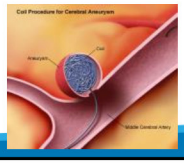
US EYE

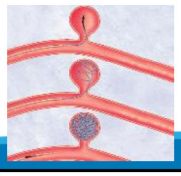
Still More Clues

- CN III palsy caused by aneurysm
  - 20% die within 48 hrs from rupture
  - 50% overall die
  - Average time from onset to rupture – 29 days
    - 80% rupture w/i 29 days
  - Many never make it to hospital
- Ruptured aneurysms
  - 5% surgical mortality
  - 60% functional impairment post-op
- Unruptured aneurysms
  - No mortality; 75% with normal outcomes; 50% with CN III recovery

US EYE

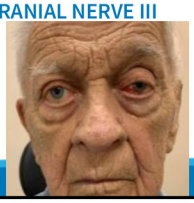






US EYE

NEVER DILATE A PATIENT WITH CRANIAL NERVE III PALSY

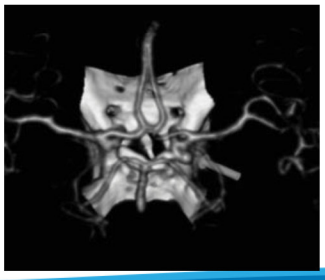


US EYE

Rules for CN III palsy imaging

- High suspicion of aneurysm: DSA (gold standard)
- CT/CTA is preferred non-invasive imaging for CN III palsy
  - CT for SAH
- CTA requires contrast- renal impairment prefers MRI/MRA
- CTA superior to MRI when patient can't have MRI
  - Pacemaker, claustrophobia
- MRI superior for non-aneurysmal causes (tumor)
  - MRA adds very little time to scan
- Recent study shows majority of CN 3 palsy patients do not get the appropriate urgent imaging.

US EYE

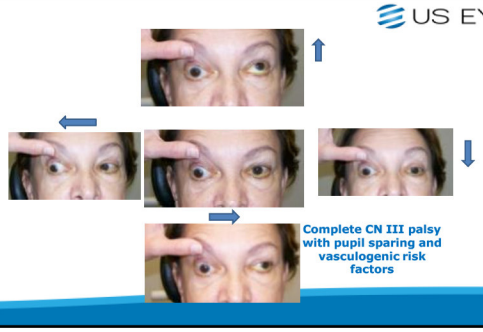


US EYE

A Different patient and Prognosis

- 63 YOF
- Diabetes and HTN
- Sudden onset retro-orbital pain

US EYE

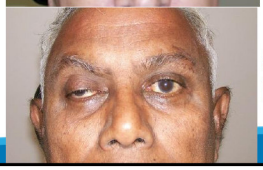


Complete CN III palsy with pupil sparing and vasculogenic risk factors

WHICH IS BETTER? ONE OR TWO?

US EYE

Resolves over several weeks



Hospitalized 23 days with 2 neurosurgical procedures

US EYE

Suspect the worst

- Optometrist sees patient with CN III palsy
- Referred to ophthalmologist next day
- Pt dies from SAH before consult

US EYE

Does presence of vasculopathic risk factors help?

- Arteriosclerotic risk factors in elderly favors microvascular etiology but does not rule out aneurysm
- HTN, DM, atherosclerosis, hyercholesterol all common and don't protect against aneurysm
- Answer: no, but makes me very nervous when NOT present

US EYE

Does acuteness of presentation help?

- Ans: Yes and No
- Aneurysm expansion usually produces acute manifestations, but chronic and evolving cases well known
- Acute is more worrisome
- Chronic and improving less worrisome but does not rule out aneurysm
- Resolved without recurrence reassuring

US EYE

Aneurysm Risk Assessment: Isolated CN 3 palsy

- Isolated dilated pupil none
- Complete CN3-normal pupil low
- Partial CN3 – normal pupil high
- Pupil involved CN3 emergency

US EYE

What to say to the ER doc

- Don't say, "*This patient has double vision*"

- Say, "*This patient has an aneurysm of the posterior communicating artery and is going to DIE if he doesn't get to neurosurgery immediately!*"

US EYE

Neuroimaging for the primary care OD

- Disclosure: I do not read MRIs (There are ODs that do- I'm not one of them)
  - What you don't know can hurt you a whole lot
  - That's the reason for residencies in radiology and subspecialties in neuroradiology
    - Thinking that I am as good is irresponsible (e.g. neuroradiologist identifying ciliary body on MRI)
- Rules for ECP: order the correct scan and read the report to ensure that the right thing was done
- If you have questions, doubts, or concerns, reach out to the radiologist
- Form a relationship with an imaging center- find out about the practice
  - Some have better results with MRA and others with CTA

US EYE

What to order, how, and why

- Disc edema/ suspect papilledema: Brain MRI with and without contrast looking for mass lesion, hydrocephalus, hemorrhage, flattened globe, empty sella; MRV looking for cerebral venous sinus thrombosis.
- Optic nerve/chiasmal disease: MRI orbits and chiasm with and without contrast with fat suppression
  - Snowball in a snowstorm
- Optic neuritis/suspect MS: MRI orbits and chiasm with and without contrast with fat suppression; MRI brain with and without contrast.
- Horner Syndrome: Brain MRI with and without contrast; CTA (or MRA) head and neck looking for cerebral artery dissection; MRI chest with lung apex and brachial plexus
  - Horner protocol or sympathetic plexus
- Suspected aneurysm (CN 3 palsy): CTA/CT and MRA/MRI with concentration to Circle of Willis
  - If high risk aneurysm-send to ER and tell them what to do.
- Don't just send to the ER without helping them. They won't get it right.

US EYE

Neuro-ophthalmic Urgencies and Emergencies

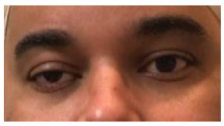
- GCA
  - Any sudden vision loss in the elderly
- Pituitary apoplexy
  - Headache, field loss, diplopia
- Aneurysm
  - Pupils
- Papilledema
  - Clinical suspicion
- Carotid dissection
  - Horner syndrome

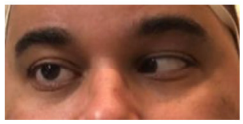
US EYE

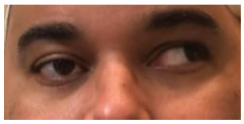
39 YOM

- Previous history of migraine developed a new and worsening headache.
- He presented to a hospital emergency room where he underwent a non-contrast enhanced computed tomography (CT) and magnetic resonance imaging (MRI) which were subsequently interpreted as normal.
  - His headache was attributed to migraine, and he was medicated as such and discharged.
- Three days later, he developed horizontal and vertical diplopia

US EYE







EYE

US EYE

39 YOM

- His visual acuity and visual fields were normal.
- He manifested a right pupil-sparing, external partial cranial nerve three palsy and concurrent right sixth nerve palsy. He also complained of worsening headache and lethargy.
- Where is the lesion?
- Let's contact the radiologist for a second reading…

US EYE

39 YOM

- He was immediately sent for repeat imaging to include contrast-enhanced MRI of the parasellar area and MRA to rule out intracavernous aneurysm and pituitary apoplexy.
- Imaging revealed a pituitary macroadenoma with intratumor hemorrhage consistent with pituitary apoplexy.
- Lateral spread into the right cavernous sinus and possible spread into the left cavernous sinus as well.
- No mass effect on the optic chiasm or prechiasmal intracranial portion of the optic nerve.
  - Hence normal acuity and fields
- The patient was immediately admitted for endocrinological and neurosurgical evaluation

US EYE

Pituitary apoplexy

- Pituitary apoplexy is a severe and potentially fatal medical condition complicating 2-12% of pituitary adenomas and characterized by the variable association of headache, vomiting, visual impairment, ophthalmoplegia, altered mental state and consciousness, lethargy, and panhypopituitarism.
- Hemodynamic instability may be result from adrenocorticotrophic hormone deficiency, which can be fatal.
- •Occurs due to a rapid expansion, mainly caused by hemorrhage or infarction of a preexisting (known or unknown) adenoma

US EYE

Pituitary apoplexy

- Most common presenting symptom occurring in 90 % of patients is sudden onset of severe headache
  - Commonly described as frontal or retro-orbital.
    - Pituitary apoplexy is often overlooked as a possible cause of "thunderclap headache" where diagnostic evaluations tend to direct to more common causes of this presentation including subarachnoid hemorrhage, cerebral venous sinus thrombosis, and cervical artery dissection.
- Approximately 50% have visual abnormalities
  - •Blurred vision
- Cranial nerve palsy (CN III) or palsies
  - Cranial nerve VI most common, followed by CN III
- Visual field defects
  - Bitemporal hemianopsia
- Facial weakness

US EYE

Pituitary apoplexy

- Most symptomatic patients undergo CT scanning in an emergency setting due to the clinical suspicion of acute intracranial hemorrhage
- Acute hemorrhagic infarct may be seen on CT
  - Non-hemorrhagic infarcts will usually show no abnormalities without intravenous contrast
- MRI with contrast is the most effective imaging in cases of suspected pituitary apoplexy
  - MRI is superior to CT

US EYE

Pituitary apoplexy

- Positive outcome in most cases
  - Conservative medical treatment
  - Stabilize and replace diminished pituitary hormones
- Surgical decompression
  - Trans-sphenoidal or subfrontal transcranial approach
  - Patients with visual impairment and neuro-ophthalmic dysfunction will be selected for surgery.
- Patient was medically stabilized, and surgery delayed due to COVID lock down
- Ultimately underwent successful surgical decompression

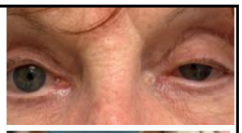
US EYE

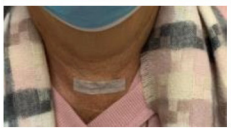
Neuro-ophthalmic Urgencies and Emergencies

- GCA
  - Any sudden vision loss in the elderly
- Pituitary apoplexy
  - Headache, field loss, diplopia
- Aneurysm
  - Pupils
- Papilledema
  - Clinical suspicion
- Carotid dissection
  - Horner syndrome

78 YOF

- Sudden onset of ptosis OS
- Immediately following parathyroid surgery
- Headache and eye pain
- Dilation lag and positive lopidine test

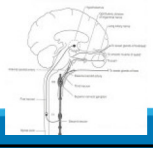




WHAT IS HORNER'S SYNDROME?

US EYE

A triad of clinical signs arising from disruption of sympathetic innervation to the eye and ipsilateral face that causes *miosis*, upper lid *ptosis*, mild elevation of the lower lid, and *anhydrosis* of the facial skin.



What is the most likely cause?

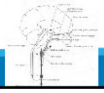
US EYE

- Lung cancer
- Carotid dissection
- Direct surgical trauma to the nerve
- Migraine

HORNER'S SYNDROME: ETIOLOGIES

US EYE

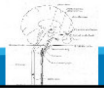
- First-order neuron disorder: Stroke (e.g., vertebrobasilar artery insufficiency or infarct); tumor; multiple sclerosis (MS), and, rarely, severe osteoarthritis of the neck with bony spurs.
- Second-order neuron disorder: Tumor (e.g., lung carcinoma, metastasis, thyroid adenoma, neurofibroma). Patients with pain in the arm or scapular region should be suspected of having a Pancoast tumor. In children, consider neuroblastoma, lymphoma, or metastasis.



HORNER'S SYNDROME: ETIOLOGIES

US EYE

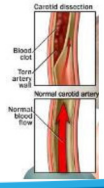
- Third-order neuron disorder: Headache syndrome (e.g., cluster, migraine, Raeder paratrigeminal syndrome), internal carotid dissection, herpes zoster virus, otitis media, Tolosa–Hunt syndrome, neck trauma/tumor/inflammation, prolactinoma.
- Congenital Horner syndrome: Trauma (e.g., during delivery).
  - Heterochromia
- Other rare causes: Cervical paraganglioma, ectopic cervical thymus

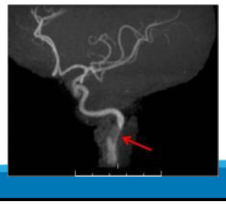


Carotid Dissection

US EYE

- *A 3rd-order Horner's and ipsilateral head, eye, or neck pain of acute onset should be considered diagnostic of internal carotid dissection unless proven otherwise.*





Carotid Dissection

US EYE

- Carotid artery dissection presents with the sudden or gradual onset of ipsilateral neck or hemicranial pain, including eye or face pain
- Often associated with other neurologic findings including an ipsilateral Horner's syndrome, TIA, stroke, anterior ischemic optic neuropathy, subarachnoid hemorrhage, or lower cranial nerve palsies
  - 52% with ocular or hemispheric stroke with 6 days
    - 67% within first week; 89% within 2 weeks; none after 31 days
- Horner's from suspected carotid dissection should go to ER

US EYE

What to say to the ER doc

- Don't say, "*This patient has a little ptosis and a little pupil.*"
- Say, "*This patient has a carotid artery dissection and will stroke out unless they get a CTA and referred to a stroke neurologist now!*"

US EYE

Neuro-ophthalmic Urgencies and Emergencies

- GCA
  - Any sudden vision loss in the elderly
- Pituitary apoplexy
  - Headache, field loss, diplopia
- Aneurysm
  - Pupils
- Papilledema
  - Clinical suspicion
- Carotid dissection
  - Horner syndrome

US EYE

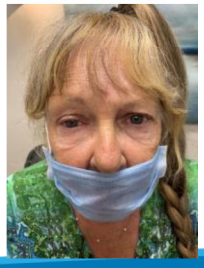
IF YOU LISTEN TO PATIENTS, THEY WILL TELL YOU THE DIAGNOSIS

US EYE

73 YOWF

- CC: swollen left eyelid x 3 months
- Not happy with previous doctor
  - *"They aren't listening to me"*
- Highly allergic person- had pain and ear blockage on right side of face while gardening- thinks something got into her eye
- Rx Zylet, Azasite, oral antihistamines, hot and cold compresses- no improvement
- PCP tested for GCA- negative
- Presumed allergic reaction
  - No itching, persistent and unilateral
- Hypothyroid, smoker

US EYE



US EYE

US EYE

IMMEDIATELY REFERRING TO THE EMERGENCY DEPARTMENT IS ACCEPTABLE MANAGEMENT…IF YOU
ARE WILLING TO HELP

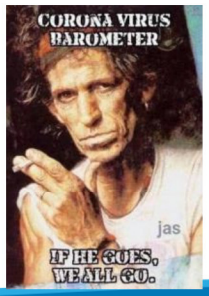
US EYE

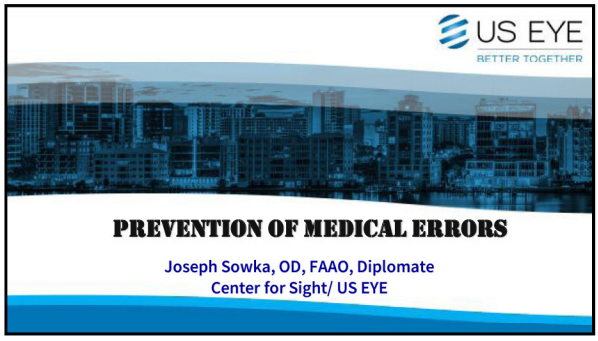
Best handled in the ED*

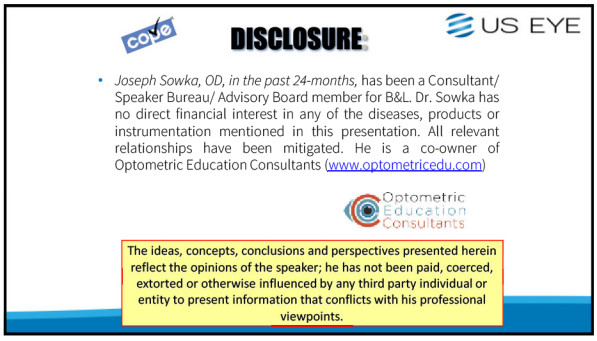
- Suspected GCA
- Suspected aneurysm
- Suspected papilledema
- Suspected pituitary apoplexy
- Suspected carotid dissection
- CRAO/ BRAO/ TIA

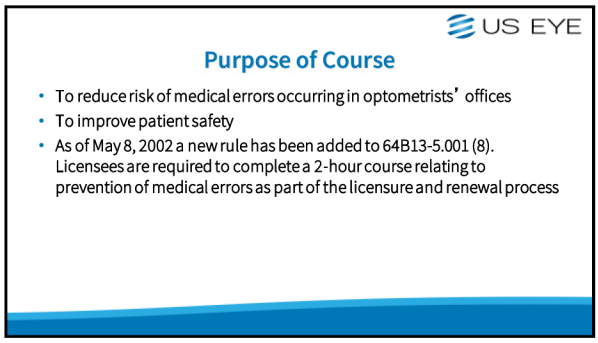
*As long as you are willing to help

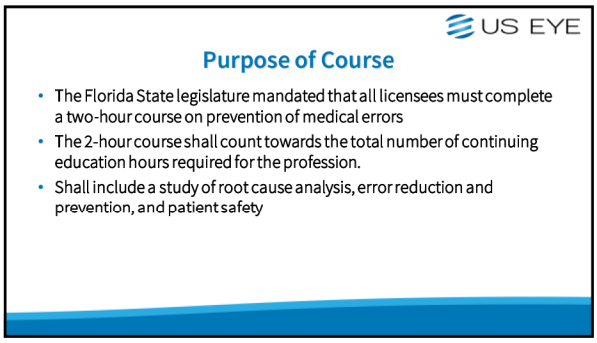
US EYE

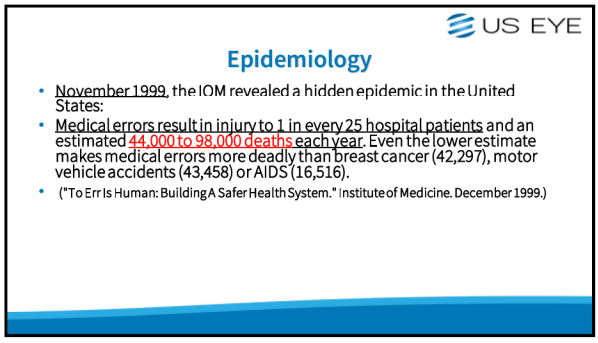


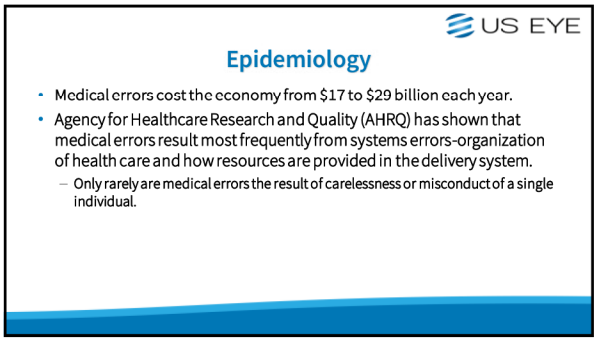

US EYE
BETTER TOGETHER
PREVENTION OF MEDICAL ERRORS
Joseph Sowka, OD, FAAO, Diplomate
Center for Sight/ US EYE


COVID
DISCLOSURE:
US EYE
Joseph Sowka, OD, in the past 24-months, has been a Consultant/ Speaker Bureau/ Advisory Board member for B&L. Dr. Sowka has no direct financial interest in any of the diseases, products or instrumentation mentioned in this presentation. All relevant relationships have been mitigated. He is a co-owner of Optometric Education Consultants (www.optometricedu.com)
Optometric Education Consultants
The ideas, concepts, conclusions and perspectives presented herein reflect the opinions of the speaker; he has not been paid, coerced, extorted or otherwise influenced by any third party individual or entity to present information that conflicts with his professional viewpoints.


US EYE
Purpose of Course
To reduce risk of medical errors occurring in optometrists' offices
To improve patient safety
As of May 8, 2002 a new rule has been added to 64B13-5.001 (8). Licensees are required to complete a 2-hour course relating to prevention of medical errors as part of the licensure and renewal process


US EYE
Purpose of Course
The Florida State legislature mandated that all licensees must complete a two-hour course on prevention of medical errors
The 2-hour course shall count towards the total number of continuing education hours required for the profession.
Shall include a study of root cause analysis, error reduction and prevention, and patient safety


US EYE
Epidemiology
November 1999, the IOM revealed a hidden epidemic in the United States:
Medical errors result in injury to 1 in every 25 hospital patients and an estimated 44,000 to 98,000 deaths each year. Even the lower estimate makes medical errors more deadly than breast cancer (42,297), motor vehicle accidents (43,458) or AIDS (16,516).
("To Err Is Human: Building A Safer Health System." Institute of Medicine. December 1999.)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Epidemiology
Medical errors cost the economy from $17 to $29 billion each year.
Agency for Healthcare Research and Quality (AHRQ) has shown that medical errors result most frequently from systems errors-organization of health care and how resources are provided in the delivery system.
Only rarely are medical errors the result of carelessness or misconduct of a single individual.

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1999 INSTITUTE OF MEDICINE (IOM) REPORT—IS LIMITED AND OUTDATED.

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- **1999 IOM report underestimated the magnitude of the problem**
- **A 2004 report of inpatient deaths associated with the Agency for Healthcare Quality and Research Patient Safety Indicators in the Medicare population estimated that 575 000 deaths were caused by medical error between 2000 and 2002, which is about 195 000 deaths a year**

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Causes of death, US, 2013

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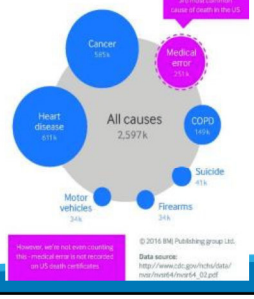

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Are medical errors really the third biggest cause of death?

mcdreeamiemusings.com @mcdreeamie

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WHY WE ARE REALLY DOING THIS?

String of Errors Put Florida Hospital on the Critical List

April 14, 1995 | MIKE CLARY | SPECIAL TO THE TIMES

TAMPA — Diabetic and disabled, 51-year-old Willie King seems an unlikely figurehead for a national uprising over patients' rights. Two months ago, the retired heavy-equipment operator checked into University Community Hospital here to have his diseased right leg amputated. A doctor cut off his left leg instead.

"When I came to and discovered I lost my good one, it was a shock, a real shock," King said in a press conference three weeks after the fiub. no operation. "I told him: 'Doctor, that's the wrong leg.' "

Dr. Sanchez testified that he learned of his error from a nurse as he was still cutting through the leg of the patient, Willie King, 52. After reviewing the patient's file, she had started to shake and cry. But by that point, he said, there was no turning back. "I tried to recover from the sinking feeling I had," he testified, as his eyes grew moist and his voice trailed off.

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Types of Medical Errors

- The IOM report defines an error as:
  - The failure of a planned action to be completed as intended (i.e., error of execution)
    - Tobrex instead of Tobradex
  - The use of a wrong plan to achieve an aim (i.e., error of planning).
    - Viroptic on bacterial conjunctivitis
    - Tobradex on dendrite

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Types of Medical Errors

- An adverse event is an injury caused by medical management rather than the underlying condition of the patient (e.g. allergic response to a drug). An adverse event attributable to error is a preventable adverse event, also called a sentinel event, because it signals the need to ask why the error occurred and make changes in the system (prescribing drug to which patient is allergic because you didn't ask).

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Why Errors Happen

- Active Errors: Active errors occur at the level of the frontline operator, and their effects are felt almost immediately.

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Why Errors Happen

- Latent errors: Latent errors tend to be removed from the direct control of the operator and include things such as poor design, incorrect installation, faulty maintenance, bad management decisions, and poorly structured organizations.

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Latent Error – Sentinel Event

- Pt develops CN III palsy from aneurysm
  - Treatment choices: aneurysm clip or endovascular coil packing
- Successfully treated with aneurysm clip
  - All coils are inert and MRI safe; not all clips are MRI safe
- Radiology tech doesn't verify type of clip
- Pt undergoes F/U MRI with non-MRI safe clip in major medical center
- Clip displaces during MRI
- Patient has fatal hemorrhage during procedure
- Patient survived disease…but not the treatment

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Latent Error

Clinical Leadership & Infection Control

CHOP sued after 23 infants contract, 1 dies from eye infection in 2016 sterilization breach

Written by Alyssa Rege | August 31, 2018 | Print | Email

3. At least 23 infants in CHOP's NICU contracted viral infections stemming from the same sterilization breach in 2016. The figure represented more than half of the 43 infants who underwent eye exams in the NICU during the same period, the hospital wrote in a four-paragraph report in the June 2017 issue of the *American Journal of Infection Control*. All 23 patients suffered respiratory symptoms, and five went on to develop pneumonia. Eleven of the 23 infants experienced infectious symptoms in their eyes. Six hospital employees and three parents also contracted viral infections, according to the case study. The case study did not mention patient deaths.

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Latent Error

West Virginia National Guard: 42 residents accidentally given Regeneron antibody treatment instead of COVID-19 vaccine

Medical experts believe there is no risk of harm to those individuals

From Staff Reports Dec 31, 2020 1 1 min to read

CHARLESTON, W.Va. (WV News) — Forty-two people at a COVID-19 vaccination clinic hosted by staff at the Boone County Health Department received the Regeneron Antibody product instead of the Moderna vaccine.

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Diagnostic Inaccuracies

- Incorrect diagnoses may lead to incorrect and ineffective treatment or unnecessary testing.
- Inexperience with a technically difficult diagnostic procedure can affect the accuracy of the results.
  - Study that demonstrated that measuring blood pressure with the most commonly used type of equipment often gives incorrect readings that may lead to mismanagement of hypertension.

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Diagnostic Inaccuracies

- Types of Diagnostic Error
  - Misdiagnosis leading to an incorrect choice of therapy (Steroid Combo med on a Dendrite)
  - Failure to use or order an indicated diagnostic test (VF, CV, eye not correctable to 20/20)
  - Misinterpretation of test results
  - Failure to act on abnormal results

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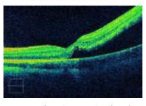
Snatching defeat out of the jaws of victory

- Pt presents with reduced acuity (20/50)
- OD diagnoses CSC based upon OCT
  - Doesn't dilate to confirm
- Case goes to trial- OD prevails
  - Poor expert witness for plaintiff
- Verdict gets overturned on appeal
  - Technicality
- Goes back into litigation

Representative image



If you are going to use technology, please interpret results correctly

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Failure to order the proper test or referral

- Thursday: 58 YOM with vision loss OD: Dx AION OD > OS; mild headache and pharyngitis
  - Recommended: OCT (ordered), ESR, CRP, platelets (not ordered)
- Friday: OCT performed
- Saturday: OCT interpreted- disc swelling OD > OS
  - CTJ moment; fax to PCP for serology "ASAP". Office not open
- Sunday: Nothing
- Monday: message read
  - Serology and carotid testing set for Wednesday evening
- Tuesday: pt wakes up with profound vision loss OS
  - Walks into ER and gets tests done- everything elevated
  - Dx: temporal arteritis- legally blind

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Conditions that Create Errors

- Precursors or Preconditions
  - A need to have the right equipment, well-maintained and reliable
  - A skilled and knowledgeable workforce
  - Reasonable work schedules
  - Well-designed jobs
  - Clear guidance on desired and undesired performance
- Preconditions are latent failures embedded in the system

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Factors and Situations That Increase the Risk of Errors

- Fatigue
- Alcohol and/or other Drugs
- Illness
- Inattention/Distraction
- Emotional States
- Unfamiliar Situations
- Communication Problems
- Illegible Handwriting

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Medication Errors

- Problems related to the use of pharmaceutical drugs account for nearly 10 percent of all hospital admissions, and significantly contribute to increased morbidity and mortality in the United States (Bates. 1995).

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- Medication errors are thought to cause 7,000 deaths annually – more than the 6,000 deaths that occur each year in the workplace. The annual cost of medication errors is at least $2 billion

Top 10 Medication Errors

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1. Sound-a-like Drugs
2. Lack of Drug Knowledge
3. Dose Calculation Errors
4. Decimal Point Misplacement
5. Wrong Dosage Form
6. Wrong Dosage Frequency
7. Use of Abbreviations
8. Drug Interactions
9. Renal Insufficiency
10. Incomplete Patient History

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Sound-a-Like Meds

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Vexol (rimexolone) Ophthalmic drops

Vs.

Vosol (acetic acid) Otic drops

Sound-a-Like Meds

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- Tobrex (tobramycin) Ophthalmic drops

Vs.

- Tobradex (tobramycin and dexamethasone) Ophthalmic drops

Case

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- A pediatric ophthalmologist prescribed TOBREX (tobramycin) 0.3% ophthalmic drops for a one-month-old infant with a dacryocystitis (one drop TID to the left eye). The physician indicated this drug by checking off a space on a preprinted prescription order form which listed 12 different ophthalmic drops including TOBRADEX (tobramycin and dexamethasone) which appeared on the line above Tobrex.

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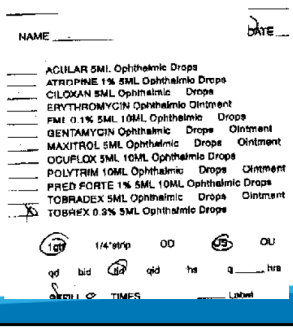

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Same Drug – Different Direction

- Prescribed Tobradex
- Patient fails to improve
- Produces bottle of Tobrex
- Whose mistake? Doctor? Pharmacy? Company?
- Ask to see medications at follow-up

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Computerized Drug Ordering

- A physician selected OCCLUSAL-HP (17% salicylic acid for wart removal) instead of OCUFLOX (ophthalmic ofloxacin) from a alphabetical product list in a computerized prescriber order entry system and sent the prescription to a hospital outpatient pharmacy with directions to "use daily as directed."

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Sound-a-Like Meds

Zymar (gatifloxacin) Ophthalmic drops

Vs.

Zymase (amylase, lipase, protease) capsules for digestion

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Sound-a-Like Meds

- Ocuflox (ofloxacin 0.3%) Ophthalmic drops (Allergan)

Vs.

- Ocufen (flurbiprofen 0.03%) Ophthalmic drops (Allergan)

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SOUND-A-LIKE MEDS

AcetaZOLAMIDE (Diamox) Vs.

AcetoHEXAMIDE (Dymelor)

Type 2 diabetes treatment

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SOUND-A-LIKE MEDS

VitA-POS (ocular lubricant)

Vs.

Vitaros (erectile dysfunction crea

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- **Due to a doctor's illegible handwriting, a woman was prescribed the ocular lubricant VitA-POS, was given the erectile dysfunction cream Vitaros instead. The patient suffered eye pain, blurry vision, redness, and yes—swelling. The dispensing pharmacist didn't stop to question why an erectile dysfunction drug was prescribed to a woman, which should have at least given him a reason to double check.**

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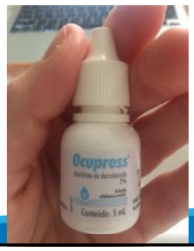
Sound-a-Like Meds



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Sound-a-Like Meds

- Refresh Liquigel

Vs.

- RePhresh Vaginal Gel

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LOOK-A-LIKE PACKAGING

- The problem of packaging similarities with ophthalmic medications is related in part to FDA approval of a color-coding system by pharmacologic class, making all products within a class the same color.

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LOOK-A-LIKE PACKAGING

- Sulfacetamide, Tobramycin, Neomycin

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LOOK-A-LIKE PACKAGING

- Sulfacetamide, Tobramycin, Neomycin, Ocufloxacin

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LOOK-A-LIKE PACKAGING

- Generics are no different

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Look-a-Like Meds

- Precision Glucose Control Soln vs. Timolol

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LOOK-A-LIKE PACKAGING

- Ophthalmic

Vs.

- Otic

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LOOK-A-LIKE PACKAGING

- Ophthalmic

Vs.

- Otic

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LOOK-A-LIKE PACKAGING

- FML Forte

Vs.

- Pred Forte

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LOOK-A-LIKE PACKAGING

- ALREX vs. NAIL GLUE

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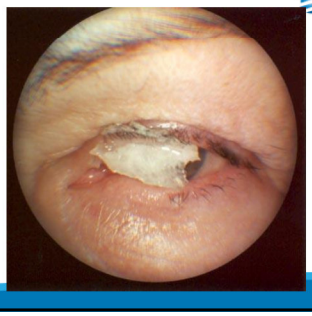

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Clear Care: Still causing eye injuries

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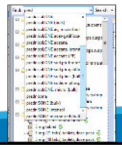
Med Module Changes

- **Effort to use a combination of upper- and lower-case letters to differentiate drugs, called "Tall Man lettering"**
- **Using that system, the potentially confusable drugs "prednisone" and "prednisolone" would be written as "predniSONE" and "prednisoLONE" to tell them apart**



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PRACTICE RECOMMENDATIONS

- Special care to Sound-a-like and Look-a-Like Medications
- Avoid pre-printed prescription pads if possible
- Review your Erx thoroughly
- Have patient bring all medications that you've prescribed with them
- Patient Education

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Error Prevention

- Identification and Evaluation of Error
- Hospital Mortality and Morbidity Meetings
  - Recourse free error reporting protocol
- Automated Equipment
  - Recall system
  - Medication ordering systems/software
- Professional Continuing Education

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Doctor-Patient Communication

- Know all your patient's medications, vitamins and herbs
- Question about allergies and past adverse reactions to medications
- Write prescriptions legibly so patients and pharmacists can read them

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Patient Education

- DO NOT rely on the Pharmacist
- What is the medicine for?
- How is it supposed to be taken?
- What side effects are likely?
- What to do if side effects occur?
- Drug interactions?
- What food, drink or activity should be avoided or included?
- Have patient check meds from pharmacy
- Which generics are not acceptable
- Encourage Patient's questions!

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Professional Communication

- Inter and Intra professional communication
- Communicate with patient's other healthcare providers to coordinate care.

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Root-Cause Analysis

- Understanding Why Errors happen
- JCAHO requires that a thorough, credible RCA be performed for each reported sentinel event.
  - What Happened?
  - Why did it happen?
  - What do you do to prevent it from happening again?

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Patient Safety

- Stress dose adjustment in children and elderly patients
- Limit Access to high hazard drugs
- Use protocols for high hazard drugs
- Computerized drug order entry
- Use pharmacy-based IV and drug mixing programs
- Standardize drug packaging, labeling, storage
- Use "unit dose" drug systems (packaged and labeled in standard patient doses)

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Patient/Office Safety

- Standards for Healthcare Professionals
- Licensing, Certification and Accreditation
- Role of Professional Societies
- Infection Prevention
  - Tonometer tip, gonioprism, etc.
- OSHA
- CPR/EMS
- Handling common medical emergencies
  - Vasovagal Syncope

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Reducing Medical Errors within the Optometric Practice

Malpractice and How it Happens – a Look at Some Cases

Malpractice

- A dereliction of professional duty or a failure to exercise an ordinary degree of professional skill or learning by one (such as a physician) rendering professional services which results in injury, loss, or damage.
- An injurious, negligent, or improper practice

Role of the Expert Witness

- Handle an adversarial situation
- Be fair and objective
- Be balanced
- Educate
- Optometry vs ophthalmology

Three Main Offenders

- Failure to detect retinal detachment
- Failure to detect glaucoma
- Failure to detect tumor

In Other Words…

- Failure to listen to the patient
- Failure to observe the signs
- Failure to make the diagnosis fit the findings
  - Not vice-versa
- Failure to do the appropriate tests and follow-up
- Failure to make the proper referral
- Making a diagnosis of exclusion the first diagnosis instead of the last

Failure to Observe the Signs

- A 16-year-old male presents for contact lens fitting.
- His refraction is: +1.00 - 1.00 x 180 - 20/40
  +0.75 - 0.50 x 005 - 20/20
- Fundus – "WNL"; no c/d ratio
- He is diagnosed with refractive amblyopia OD and fit with contact lenses.
- At 2-week f/u, his VA is 20/100 OD – "good fit" recorded.

Failure to Observe the Signs

- One month f/u – 20/200 OD – "good fit"
- Discharged
- Annual exam:
  - Refraction unchanged – 20/400 OD, 20/20 OS
  - Fundus WNL
  - New lenses ordered
- Contact lens dispense – "Right lens not clear"
  - Retinal detachment OD
- Recommendation: Seek settlement

Failure to Diagnose Retinal Detachment

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- 50 YOWM
- Sees flashes and floaters
- Presents to optometrist
- Dilation and BIO performed
  - "Ø breaks, Ø detachment" recorded
- Patient warned signs and symptoms RD
- Dismissed

Failure to Diagnose Retinal Detachment

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- Patient has worsening of symptoms and vision loss one week later
- Telephones optometrist who immediately directs patient to retinal specialist
  - Does not record this in the chart
- Patient now has RD
- Poor surgical outcome
- Sues OD for malpractice
- Is it malpractice? Was standard of care breached?

Failure to Diagnose Retinal Detachment

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- Could OD have missed existing break?
- Could break have been undetectable to best retinal specialist?
- Could there have been no break initially and one formed after exam?
- Bad outcome yes – malpractice no

Failure to Diagnose Retinal Detachment

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- Plaintiff attorney: "I have another optometrist that will swear that this is malpractice."
- Me: "Well, you better give him a call because I' m not doing it!"
- Plaintiff attorney: Even for $$?"
- Me: "No!"

Failure to Diagnose Retinal Detachment

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- Treating retinal specialist deposed
- Plaintiff attorney: "Could Dr. XYZ have missed the retinal break?"
- Retinal specialist: "Well, yes. It is likely he did. He is not a physician, you know".

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LEGAL POT OF GOLD

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Legal Pot of Gold

- Treating ophthalmologist opining on OD who allegedly missed angle closure.
- OD sued for infectious keratitis- is friendly with corneal specialist and recommends him as expert witness.

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Another Retina Specialist Perspective

Q. *"Do you think that you as a medical doctor, as an ophthalmologist are better trained and equipped to rule out or rule in a retinal detachment than an optometrist?'"*

A. *"I think optometrists are trained or supposedly are trained in their field to be able to do a dilated fundus exam to diagnose retinal tears or detachments as well as any other eye care professionals."*

Q. *"You believe an optometrist has the same expertise and ability to diagnose a retinal detachment or retinal tear as you do?"*

A. *"Setting my ego aside, I would say that optometrists are trained to evaluate the peripheral retina as well as an ophthalmologist and that's my answer."*

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Sometimes it is Black and White… or Worse

- 55 YOBM with 'weed whacker abrasion'
  - 2 ODs
  - Shallow chamber; IOP < 5 mm; hypopyon
  - End Result?

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"Standard of Care?"

- *"In all medical probability, the retinal break/corneal perforation/whatever-it-may be was present at the time of your examination and because you failed to see and diagnose it, you fell below the standard of care. Because the standard of care dictates that you would have s**een and diagno**sed it. And because you didn't, you were negligent".*

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Standard of Care and Negligence

- Negligence refers to a person's failure to follow a duty of conduct imposed by law.
- Every health care provider is under a duty to:
- use his/her best judgment in the treatment and care of his/her patient;
- to use reasonable care and diligence in the application of his/her knowledge and skill to his/her patient's care;
- to provide health care in accordance with the standards of practice among members of the same health care profession with similar training and experience situated in the same or similar communities at the time the health care is rendered

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Highest Degree of Skill Not Required

- The law does not require of a health care provider absolute accuracy, either in his/her practice or in his judgment. It does not hold him/her to a standard of infallibility, nor does it require of him/her the utmost degree of skill and learning known only to a few in his profession. The law only requires a health care provider to have used those standards of practice exercised by members of the same health care profession with similar training and experience situated in the same or similar communities at the time the health care is rendered

Not Guarantor of Diagnosis, Analysis, Judgment or Result

- A health care provider does not, ordinarily, guarantee the correctness of his/her diagnosis, analysis, judgment as to the nature of a patient's condition or the success of his/her health care service rendered.
- Absent such guarantee, a health care provider is not responsible for a mistake in his/her diagnosis, analysis, judgment unless he has violated the duty (one or more of the duties) previously described.

Sometimes you JUST shake your head

- Retained for defense
- Diabetic pt sees OD who diagnosis PDR OU
- Educates and warns risk permanent blindness- must see retinal specialist w/i 7 days
- Pt sees another OD 6 weeks later
- Detailed exam completely normal
- Pt now completely visually impaired from PDR

Sometimes you JUST shake your head- Part ii

- Defending OD alleged to have misdiagnosed PXG
- Affidavit- *"There was no evidence of glaucoma at this time"*

A Festival of Ignorance

- 37 YOF- pterygium surgery. PF post-op
- Sees OD 3 weeks p/o. Some blur
  - No IOP
- Sees another OD next day
  - Dilates; swollen nerve, refers, no IOP
- Sees retinal specialist same day
  - IOP 49.5 mm Hg
  - Injects steroid
- All 3 sued for missing steroid induced glaucoma
- Does any glaucoma cause a swollen nerve?

A Festival of Ignorance

- Plaintiff's expert witness:
- *"Pallor is common in glaucoma"*
- *"This case had extremely fast progression of the field loss"*
- *"Glaucoma commonly occurs with minimal cupping"*
- *"Extremely high intraocular pressure commonly causes a swollen nerve"*
- *"You never consider ischemic neuropathy in a patient under 70 years"*

A Festival of Ignorance: Part II

- 55 YOF; cerebral palsy; poorly communicative; some discomfort OS
  - *NLP OD; 20/200 OS; -13.00 DS OU*
  - *Treated at ER for abrasion; OD sees no abrasion in consult*
    - *Refers to ophthalmologist- never goes*
- *Caregiver perceives worsening visual function- goes back to ER: IOP 38 mm OS- Dx: angle closure*
  - *Airlifted to another hospital ($38,000)*
  - *On call ophthalmologist won't go in (January 1)*
  - *Phones in Diamox, timolol, pilocarpine*
- *Pt has uveitis*
- *Numerous condemnations again OD by expert witness*
  - *Needed to dilate; uveitis not blinding; IOP of 38 immediately blinding*

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Surviving the Legal Process

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THE MOST IMPORTANT THING TO REMEMBER

It isn't personal…it's just business

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Am I Being Sued?

- Subpoena for your records
  - Most likely not being sued
    - Accidents, disability, etc.
  - Send immediately
    - 10-day window
    - Make sure records complete…and unaltered
- Notice of Intent to Litigate
  - Now you are being sued

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Notice of Intent to Litigate

- Notice immediately tries to beat you into submission.
- Doesn't mention your care or your exam, but your *negligence*
  - "Prior to your *negligence*…", "As a result of your *negligence*…", "Was there anything subsequent to your *negligence*…"
- DO NOT respond to this yourself
  - Contact insurance company- get attorney

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It All Lies in the Depositions

- Attorneys representing all parties involved
- Court reporter/videographer
- No judge or jury
- Fact finding mission
- Don't volunteer information
  - Won't convince them they were wrong to file suit – cases aren't won in deposition, but they are lost
- Insist on home field advantage

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It All Lies in the Depositions

- Trial is nothing more than a performance
  - Written
  - Rehearsed
  - Hair and makeup
  - Jury is the audience
  - No smoking guns
  - Everything comes from the depositions
    - The "Script"

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Just answer the question

- You have to answer unless instructed not
  - Your attorney will object throughout- still answer
- Don't try to educate plaintiff's attorney
  - Could give beneficial information not otherwise asked
- Avoid temptation to give "great" testimony
  - You'll have your chance in court
- Be prepared and be professional

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Beware wolves in sheep's clothing

- Deposition is adversarial
- Some attorneys will intimidate, others will kill with kindness
  - He/she is the enemy
  - Wants information to use against you
  - Always keep up your guard
- Get comfortable with attorney – agree to something medically ridiculous
- If tired – take a break

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Look in the mirror

- Appearance and demeanor as important as testimony*
  - Be neat
  - Avoid anger, hostility, condescension*
    - *"ODs are just failed physician wannabes"*
      - 172 medical schools; just 23 optometry colleges
- Questions phrased to make you appear dishonest*
  - Keep concentration and composure
  - Attorney may become intimidated by your resilience

*It's not personal…it's just business

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Know what you are answering

- Attorney is not medical professional
  - May ask confusing questions
  - Ask for question to be repeated or rephrased
- Don't be intimidated into answers the attorney wants
  - Very few absolutes in life
- You must answer 'yes' or 'no'
  - You can explain yourself <u>after</u> answering
    - Not before- becomes adversarial

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Red flags

- "Would you agree that…"; "Is it a fair statement…"
  - Typically precede proposition that is too broad to be answered by yes or no.
- These questions are fashioned to elicit material to use against you.
- Think before you speak

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One at a time

- Let attorney finish question before answering
  - Understand question before responding
  - Court reporter can only transcribe so fast
    - Complete question won't be in transcript
  - Your attorney has time to voice objections
- Be sure that entire question is accurate before saying yes
  - If any portion inaccurate or illogical – say no

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Sometimes you cannot remember

- Facts occurred several years ago
  - Refer to records during questioning
- What about questions with no recollection or records?
  - If you remember – say so
  - If you don't remember – say so
  - Don't guess or speculate

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Watch what you are answering

- Hypothetical questions are posed only to be used against you
- Sometimes a hypothetical question cannot be answered
- Make sure that you agree with entire hypothetical before answering
- No rule that you must have opinion on hypothetical

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- It is not a crime to meet with your attorney
  - May try to intimidate
- Nothing is off the record
  - Keep your mouth shut
- Tell the truth
  - There are very few cases that can't be defended on the facts
  - There are very few cases that can be defended if the defendant is caught lying.

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Hold to your opinion

- Attorney will try to imply that you are lying
  - Hold firm to your opinion
- If attorney doesn't like your answer, he/she will repeat with prefaces " Are you telling us under oath…" or "Is it really your sworn testimony that…"
  - Don't be intimidated
  - Your answer is your answer; if asked repeatedly, repeatedly give the same answer
    - Rope-a-dope

US EYE

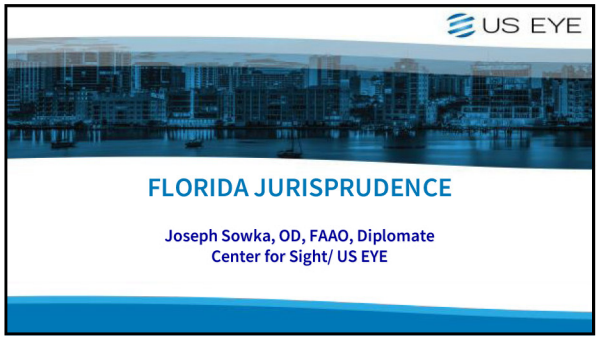
Prepare

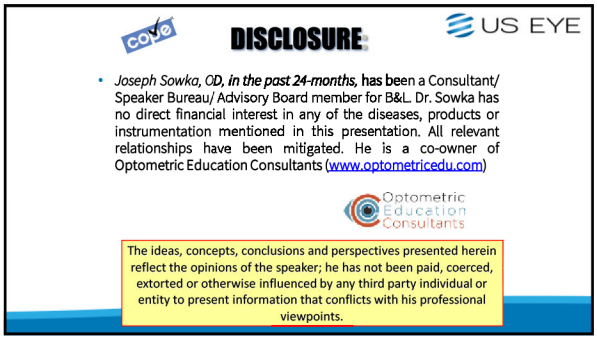
- Read! Read! Read!
- Skilled attorney can get competent physicians to agree to medical impossibilities
- Once something is said in deposition, it is written in stone.
- You will always have a chance to explain yourself in a court of law.
- You can defend virtually anything

US EYE

In Conclusion…

- Risk of malpractice is a fact of professional life
- You *will* get through it
- It will not end your life, practice, career
- It's not personal…it's just business.


US EYE
FLORIDA JURISPRUDENCE
Joseph Sowka, OD, FAAO, Diplomate
Center for Sight/ US EYE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DISCLOSURE:
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Joseph Sowka, OD, in the past 24-months, has been a Consultant/ Speaker Bureau/ Advisory Board member for B&L. Dr. Sowka has no direct financial interest in any of the diseases, products or instrumentation mentioned in this presentation. All relevant relationships have been mitigated. He is a co-owner of Optometric Education Consultants (www.optometricedu.com)
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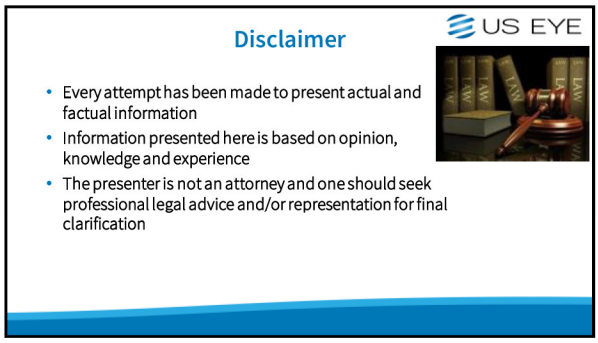
The ideas, concepts, conclusions and perspectives presented herein reflect the opinions of the speaker; he has not been paid, coerced, extorted or otherwise influenced by any third party individual or entity to present information that conflicts with his professional viewpoints.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Every attempt has been made to present actual and factual information
Information presented here is based on opinion, knowledge and experience
The presenter is not an attorney and one should seek professional legal advice and/or representation for final clarification


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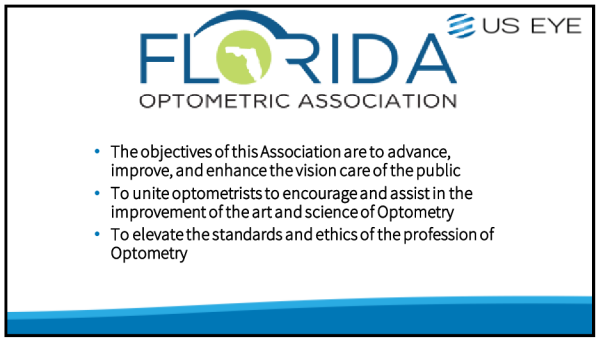
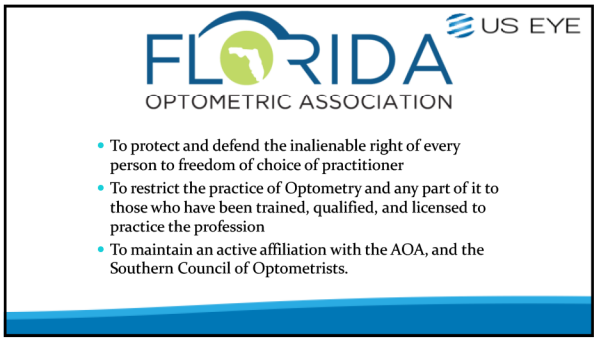
OPTOMETRIC ASSOCIATION


FLORIDA
OPTOMETRIC ASSOCIATION
US EYE
The objectives of this Association are to advance, improve, and enhance the vision care of the public
To unite optometrists to encourage and assist in the improvement of the art and science of Optometry
To elevate the standards and ethics of the profession of Optometry


FLORIDA
OPTOMETRIC ASSOCIATION
US EYE
To protect and defend the inalienable right of every person to freedom of choice of practitioner
To restrict the practice of Optometry and any part of it to those who have been trained, qualified, and licensed to practice the profession
To maintain an active affiliation with the AOA, and the Southern Council of Optometrists.

US EYE

FLORIDA | Board of Optometry

EYE

FLORIDA | Board of Optometry

- Mission: To protect, promote & improve the health of all people in Florida through integrated state, county, & community efforts.
- Vision: To be the Healthiest State in the Nation

EYE

FLORIDA | Board of Optometry

- **Purpose:** To protect the public and make Florida the healthiest state in the nation through health care licensure, enforcement, and information.
- **Focus:** To be the nation's leader in quality health care regulation.
- **Values:** I CARE (Innovation, Collaboration, Accountability, Responsiveness, Excellence)

EYE

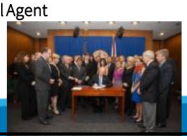
FLORIDA | Board of Optometry

The Florida Board *of* Optometry was established to ensure that every person engaged in the practice of optometry in this state meets minimum requirements for safe practice. It is the legislative intent that such persons who fall below minimum standards or who otherwise present a danger to the public shall be prohibited from practicing in this state.

US EYE

- The **Florida Board *of* Optometry** is composed of seven members appointed by the Governor and confirmed by the Senate.
- Five members of the board must be licensed practitioners actively practicing in this state.
- The remaining two members must be citizens of the state who are not, and have never been, licensed practitioners.
- Additionally, the consumer members may not be connected with the practice of optometry or with any other vision-related profession or business.
- At least one member of the board must be 60 years of age or older.

- Went into effect July 1, 2013
- Deleted ~~Topical~~ and added Ocular
- Defines Ocular Pharmaceutical Agent
- Defines Surgery



HB 239

Defines Ocular Pharmaceutical Agent

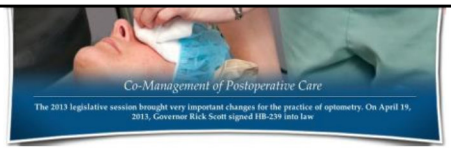
"Ocular pharmaceutical agent" means a pharmaceutical agent that is administered topically or orally for the diagnosis or treatment of ocular conditions of the human eye and its appendages without the use of surgery or other invasive techniques.

HB 239

Defines what is not Surgery

Surgery of any kind~~, including the use of lasers~~, is expressly prohibited. Certified optometrists may remove superficial foreign bodies. For the purposes of this subsection, the term "superficial foreign bodies" means any foreign matter that is embedded in the conjunctiva or cornea but that which has not penetrated the globe

- Notwithstanding the definition of surgery as provided in s. 463.002(6), a certified optometrist is not prohibited from providing any optometric care within the practice of optometry as defined in s. 463.002(7),
  - such as removing an eyelash by epilation,
  - probing an uninflamed tear duct in a patient 18 years of age or older,
  - blocking the puncta by plug,
  - or superficial scraping for the purpose of removing damaged epithelial tissue or superficial foreign bodies or taking a culture of the surface of the cornea or conjunctiva.



Defines Co-Management

- Co-management of postoperative care shall be conducted pursuant to the requirements of this section and a patient-specific transfer of care letter that governs the relationship between the physician who performed the surgery and the licensed practitioner
- The patient must be fully informed of, and consent in writing to, the co-management relationship for his or her care

US EYE

HB 239

Defines Co-Management

- The transfer of care letter shall confirm that it is not medically necessary for the physician who performed the surgery to provide such postoperative care to the patient and that it is clinically appropriate for the licensed practitioner to provide such postoperative care. The patient must be fully informed of, and consent in writing to, the co-management relationship for his or her care

US EYE

HB 239

Defines Co-Management

- Before co-management of postoperative care commences, the patient shall be informed in writing that he or she has the right to be seen during the entire postoperative period by the physician who performed the surgery

US EYE

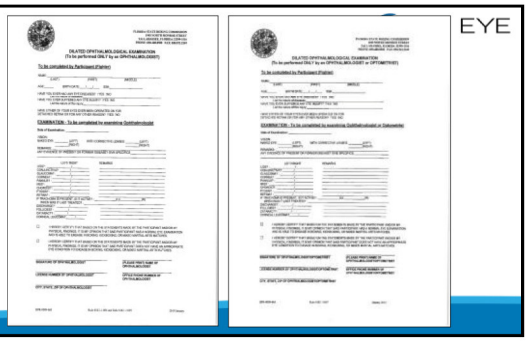
HB 239

Defines Co-Management

- The patient must be informed of the fees, if any, to be charged by the licensed practitioner and the physician performing the surgery, and must be provided with an accurate and comprehensive itemized statement of the specific postoperative care services that the physician performing the surgery and the licensed practitioner render, along with the charge for each service.

Chapter 548 Pugilistic Exhibition

- Previous exclusion: "Physician" means an individual licensed to practice medicine and surgery in this state.
- A certified optometrist is authorized to perform any eye examination, including a dilated examination, required or authorized by chapter 548 or by rules adopted to implement that chapter.
  - Boxing
  - Kickboxing
  - Mixed Martial Arts



US EYE

HB 239

Defines Topical Formulary

- The board shall establish a formulary of topical ocular pharmaceutical agents that may be prescribed and administered by a certified optometrist.

US EYE

HB 239

Defines Topical Formulary

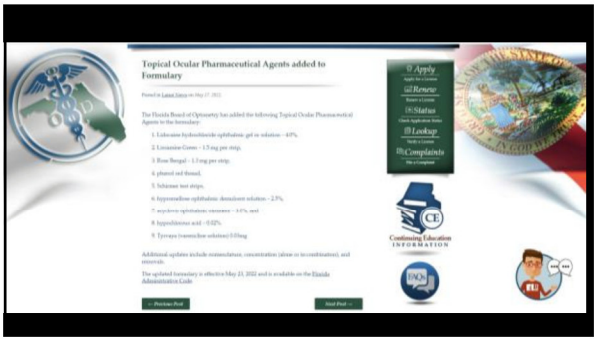
The formulary shall consist of those topical ocular pharmaceutical agents that are appropriate to treat or diagnose ocular diseases and disorders and that ~~which~~ the certified optometrist is qualified to use in the practice of optometry. The board shall establish, add to, delete from, or modify the topical formulary by rule. Notwithstanding any provision of chapter 120 to the contrary, the topical formulary rule becomes ~~shall become~~ effective 60 days from the date it is filed with the Secretary of State.

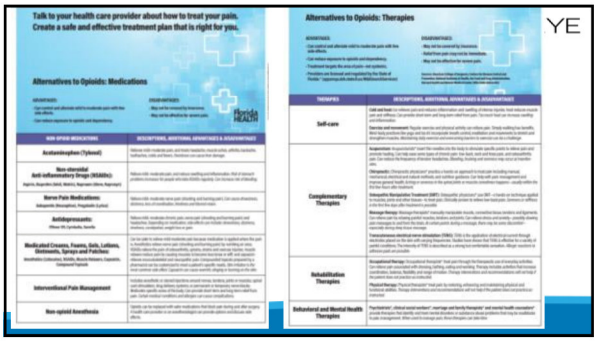
US EYE

HB 239

Topical Formulary

Any person who requests an addition, deletion, or modification of an authorized topical ocular pharmaceutical agent shall have the burden of proof to show cause why such addition, deletion, or modification should be made.



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HUMAN TRAFFICKING
Human Trafficking
Click here for new profession requirements and reporting procedures regarding Human Trafficking
Welcome to the State of Florida's Online Resource for Optometrists and Faculty Certificate Holders
Licensing, Renewals and Information


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Human Trafficking
Florida passed Human Trafficking, Chapter 2019-152, Laws of Florida, which establishes new profession requirements including newly required signs, CE/CME, and more for the following professions: Acupuncture, Medicine, Osteopathic Medicine, Chiropractic Medicine, Podiatric Medicine, Optometry, Pharmacy, Dentistry, Nursing Home Administration, Occupational Therapy, Dietetics and Nutrition, Respiratory Care, Massage Therapy, and Physical Therapy.
The Department has launched an informational website that includes a breakdown of the new law and addresses areas of: (1) signs; (2) CE/CME; (3) FAQs; (4) Specific Board of Massage requirements; and (5) Human Trafficking Reporting.
For more information please visit: http://www.flhealthsource.gov/humantrafficking/
Apply
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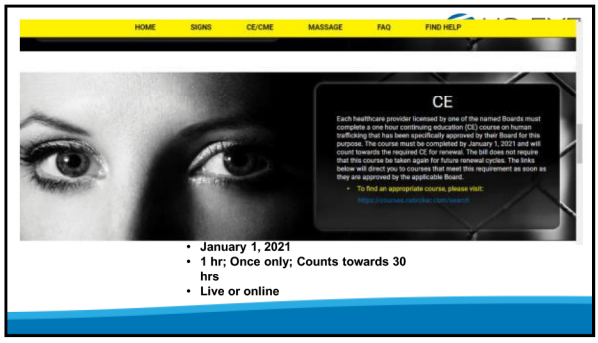
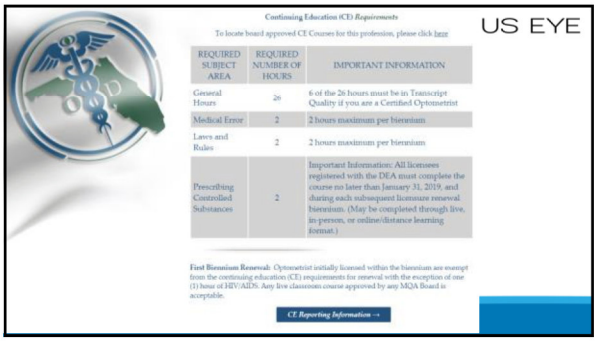
SIGNS
Each healthcare provider licensed by one of the named Boards must post a sign regarding human trafficking in a conspicuous place accessible to employees by January 1, 2021. The sign must be at least 11 x 15 inches and in at least 32-point type. The sign must contain statutorily required language and be posted in English and Spanish. The Department has also provided Mandarin translations of these signs for use in offices where those languages are spoken. The links below contain signs that meet the statutory requirements when printed at the listed size.
• Human Trafficking (English/Spanish)
• Human Trafficking (English/Spanish/Mandarin)


US EYE
If you or someone you know is being forced to engage in an activity and cannot leave,
whether it is prostitution, housework, farm work, factory work, retail work, restaurant work, or any other activity, call the National Human Trafficking Resource Center at 888-373-7888 or text INFO or HELP to 233-733 to access help and services. Victims of slavery and human trafficking are protected under United States and Florida law.


HOME
SIGNS
CE/CME
MASSAGE
FAQ
FIND HELP
CE
Each healthcare provider licensed by one of the named Boards must complete a one hour continuing education (CE) course on human trafficking that has been specifically approved by their Board for this purpose. The course must be completed by January 1, 2021 and will count towards the required CE for renewal. The bill does not require that this course be taken again for future renewal cycles. The links below will direct you to courses that meet this requirement as soon as they are approved by the applicable Board.
• To find an appropriate course, please visit:
• January 1, 2021
• 1 hr; Once only; Counts towards 30 hrs
• Live or online


US EYE
Continuing Education (CE) Requirements
To locate board approved CE Courses for this profession, please click here
REQUIRED SUBJECT AREA
REQUIRED NUMBER OF HOURS
IMPORTANT INFORMATION
General Hours
20
6 of the 26 hours must be in Transcript Quality if you are a Certified Optometrist
Medical Error
2
2 hours maximum per biennium
Laws and Rules
2
2 hours maximum per biennium
Prescribing Controlled Substances
2
Important Information: All licensees registered with the DEA must complete the course no later than January 31, 2019, and during each subsequent licensure renewal biennium. (May be completed through live, in-person, or online/distance learning format.)
First Biennium Renewal: Optometrist initially licensed within the biennium are exempt from the continuing education (CE) requirements for renewal with the exception of one (1) hour of HIV/AIDS. Any live classroom course approved by any MQA Board is acceptable.
CE Reporting Information →


IS EYE
Board Rule Approved Providers
All Optometry courses must be Board approved. All required courses must be live for the Optometry profession. Courses are listed in CEBroker.
Other Methods of Obtaining Continuing Medical Education per Biennium
20 General hours – For completion of the Florida Optometry Oral Drug Review Course & Examination.
As part of the 30 clock hours, licensed practitioners shall be required to obtain two hours in the area of Florida jurisprudence. A licensed practitioner may earn two hours in Florida jurisprudence by attending an in-person meeting of the Board at which another licensee is disciplined for no less than four (4) continuous hours or the duration of the meeting. Licensed practitioners will be required to sign-in and sign-out with board staff. Those licensed practitioners present for disciplinary purposes are not eligible to earn the two (2) clock hours for the Board meeting.
An instructor of a course may credit the hours taught towards completion of the instructor's required continuing education only once, regardless of the number of times the course is taught. However, the instructor of a course may not credit the hours taught towards completion of the "transcript quality" portion of the continuing education requirement. Continuing education hours must be obtained during the biennium preceding license renewal.
381.00593, Florida Statutes – "Public School Volunteer Health Care Practitioner Act"
Certified Optometrists NOT registered with the DEA or Optometrists may complete the 2 hour course on prescribing controlled substances to obtain 2 hours of General credit hours. (May be completed through live, in-person, or online/distance learning format.)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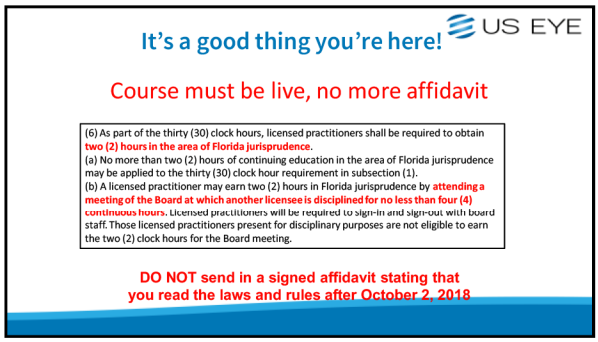
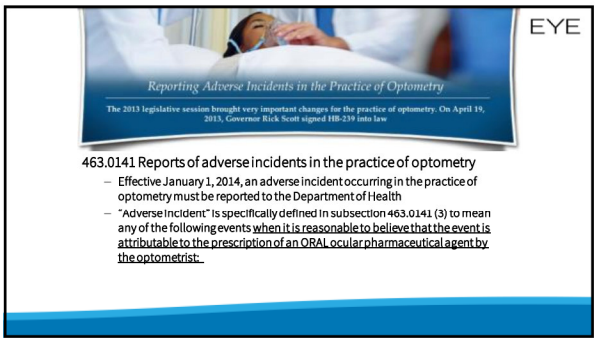
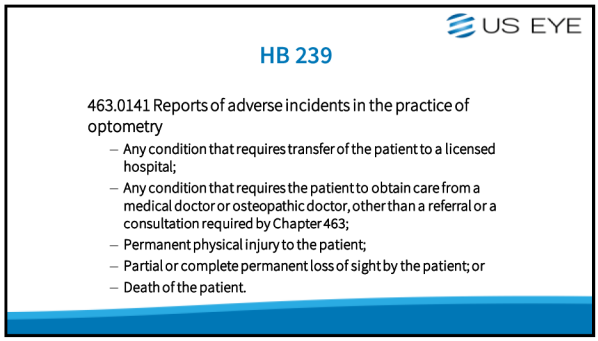
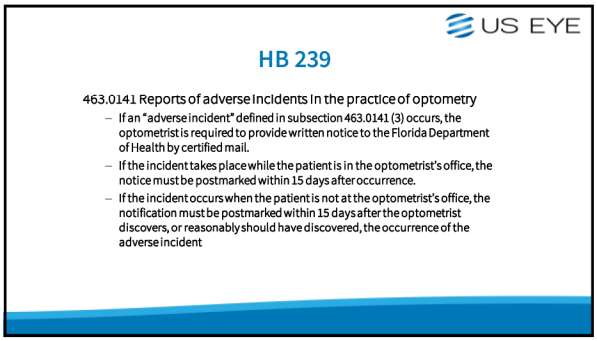

US EYE
It's a good thing you're here!
Course must be live, no more affidavit
(6) As part of the thirty (30) clock hours, licensed practitioners shall be required to obtain two (2) hours in the area of Florida jurisprudence.
(a) No more than two (2) hours of continuing education in the area of Florida jurisprudence may be applied to the thirty (30) clock hour requirement in subsection (1).
(b) A licensed practitioner may earn two (2) hours in Florida jurisprudence by attending a meeting of the Board at which another licensee is disciplined for no less than four (4) continuous hours. Licensed practitioners will be required to sign-in and sign-out with board staff. Those licensed practitioners present for disciplinary purposes are not eligible to earn the two (2) clock hours for the Board meeting.
DO NOT send in a signed affidavit stating that you read the laws and rules after October 2, 2018


EYE
Reporting Adverse Incidents in the Practice of Optometry
The 2013 legislative session brought very important changes for the practice of optometry. On April 19, 2013, Governor Rick Scott signed HB-239 into law
463.0141 Reports of adverse incidents in the practice of optometry
Effective January 1, 2014, an adverse incident occurring in the practice of optometry must be reported to the Department of Health
"Adverse Incident" is specifically defined in subsection 463.0141 (3) to mean any of the following events when it is reasonable to believe that the event is attributable to the prescription of an ORAL ocular pharmaceutical agent by the optometrist:


US EYE
HB 239
463.0141 Reports of adverse incidents in the practice of optometry
Any condition that requires transfer of the patient to a licensed hospital;
Any condition that requires the patient to obtain care from a medical doctor or osteopathic doctor, other than a referral or a consultation required by Chapter 463;
Permanent physical injury to the patient;
Partial or complete permanent loss of sight by the patient; or
Death of the patient.


US EYE
HB 239
463.0141 Reports of adverse incidents in the practice of optometry
If an "adverse incident" defined in subsection 463.0141 (3) occurs, the optometrist is required to provide written notice to the Florida Department of Health by certified mail.
If the incident takes place while the patient is in the optometrist's office, the notice must be postmarked within 15 days after occurrence.
If the incident occurs when the patient is not at the optometrist's office, the notification must be postmarked within 15 days after the optometrist discovers, or reasonably should have discovered, the occurrence of the adverse incident

Controlled Substances

- To secure DOH approval, the counterfeit-proof pad or blank must contain certain security features [i.e., must be blue or green, printed on artificial watermarked paper, must resist erasures and alterations, and "void" or "illegal" must appear on any photocopy or other reproduction of the pad or blank]; and
- To secure DOH approval, the counterfeit-proof pad or blank must also contain the preprinted name, address and category of professional licensure, or a space for the prescriber's name if not preprinted, and a space for the practitioner's DEA registration number.

Controlled Substances

- Tylenol w/Codeine - Acetaminophen 300 mg with No. 3 codeine phosphate 30 mg.
  - Only for eye conditions.
  - Cannot be used for Chronic or nonmalignant pain
  - "Chronic nonmalignant pain" means pain unrelated to cancer which persists beyond the usual course of disease or the injury that is the cause of the pain or more than 90 days after surgery.

Analgesics

- Tramadol hydrochloride
  - may not be administered or prescribed for more than 72 hours without consultation with a physician licensed under chapter 458 or chapter 459 who is skilled in diseases of the eye:

Controlled Substances

- DEA Numbers
  - Applications submitted at http://www.deadiversion.usdoj.gov/drugreg/
  - $731 every 3 years
  - 2 Controlled Substances - Schedule 3
    - A certified optometrist licensed under chapter 463 may not administer or prescribe a controlled substance listed in Schedule I or Schedule II of s. 893.03.
  - Tylenol w/Codeine - Acetaminophen 300 mg with No. 3 codeine phosphate 30 mg.
  - Tramadol hydrochloride

Antibiotics

- The following antibiotics or their generic or therapeutic equivalents:
  - Amoxicillin with or without clavulanic acid.
  - Azithromycin.
  - Erythromycin.
  - Dicloxacillin.
  - Doxycycline/Tetracycline.
  - Keflex
  - Minocycline

Antiviral

- The following antivirals or their generic or therapeutic equivalents:
  - Acyclovir
  - Famciclovir
  - Valacyclovir

Anti-Glaucoma

- The following oral anti-glaucoma agents or their generic or therapeutic equivalents, which may not be administered or prescribed for more than 72 hours:
- Acetazolamide
- Methazolamide

463.014 Certain acts prohibited

- (3) Prescribing, ordering, dispensing, administering, supplying, selling, or giving any drug for the purpose of treating a systemic disease by a licensed practitioner is prohibited. *However, a certified optometrist is permitted to use commonly accepted means or methods to immediately address incidents of anaphylaxis.*

EpiPEN® for Anaphylaxis

- EpiPen® 0.3 mg
  - **Yellow** label - 66 lbs or more
- EpiPen® Jr. 0.15 mg
  - Green label - 33-66 lbs.

463.0135 Standards of practice

- A licensed practitioner shall provide that degree of care which conforms to that level of care provided by medical practitioners in the same or similar communities. A licensed practitioner shall advise or assist her or his patient in obtaining further care when the service of another health care practitioner is required

Standards of practice

- 64B13-2.008 Probable Cause Panel.
- (1) The determination as to whether probable cause exists to believe that a violation of the provisions of Chapter 456, Part II, or 463, F.S., or of the rules promulgated thereunder, has occurred shall be made by the probable cause panel of the Board.
- (2) The probable cause panel shall be composed of at least two (2) present or former members of the Board of Optometry. At least one member of the panel must be a current Board member. At least one member shall be a present or former lay member, if available, willing to serve, and authorized by the Chair.

US EYE

456

In determining what action is appropriate, the board, or department when there is no board, must first consider what sanctions are necessary to protect the public or to compensate the patient. Only after those sanctions have been imposed may the disciplining authority consider and include in the order requirements designed to rehabilitate the practitioner. All costs associated with compliance with orders issued under this subsection are the obligation of the practitioner.

US EYE

What does this mean to you?

- When in doubt, give the money back to the patient (within reason).
  - Leading complaint to Board: failure to refund money for glasses
  - Could then lead to investigation into file
  - Take care Board doesn't overstep authority
- If a grievance is filed, you must defend yourself, preferably with the assistance of an attorney.
- Malpractice insurance typically does not cover this. You must bear the costs personally. Check with carrier now

US EYE

Minimum Equipment

The following shall constitute the minimum equipment which a licensed practitioner must possess in each office in which he or she engages in the practice of optometry:

(1) Ophthalmoscope;

(2) Tonometer;

(3) Retinoscope;

(4) Ophthalmometer, keratometer or corneal topographer;

US EYE

Minimum Equipment

(5) Biomicroscope;

(6) Phoropter or trial frame, trial lenses and prisms;

(7) Standard charts or other standard visual acuity test;

(8) Field testing equipment (other than that used for a confrontation test).

Note: Pachymeter, fundus camera, OCT, etc., not part of the minimum

US EYE

Minimum Exam

64B13-3.007 Minimum Procedures for Vision Analysis (comprehensive eye exam).

(1) Vision analysis is defined as a comprehensive assessment of the patient's visual status and shall include those procedures specified in subsection (2) below.

(2) An examination for vision analysis shall include the following minimum procedures, which shall be recorded on the patient's case record:

(a) Patient's history (personal and family medical history, personal and family ocular history, and chief complaint);

US EYE

Minimum Exam

- (b) Visual acuity (unaided and with present correction at initial presentation; thereafter, unaided or with present correction);
- (c) External examination;
- (d) Pupillary examination;
- (e) Visual field testing (confrontation or other);
- (f) Internal examination (direct or indirect ophthalmoscopy recording cup disc ratio, blood vessel status and any abnormalities);

Minimum Exam

(g) Biomicroscopy (binocular or monocular);
(h) Tonometry;
(i) Refraction (with recorded visual acuity);
(j) Extra ocular muscle balance assessment;

Minimum Exam

(k) Other tests and procedures that may be indicated by case history or objective signs and symptoms discovered during the eye examination;
(l) Diagnosis and treatment plan.
(3) If because of the patient's age or physical limitations, one or more of the procedures specified herein or any part thereof, cannot be performed, or if the procedures or any part thereof are to be performed by reason of exemption from this rule, the reason or exemption shall be noted on the patient's case record.

Minimum Exam

- Except as otherwise provided in this rule, the minimum procedures set forth in subsection (2) above shall be performed prior to providing optometric care during a patient's initial presentation, and thereafter at such appropriate intervals as shall be determined by the optometrist's sound professional judgment. Provided, however, that each optometric patient shall receive a complete vision analysis prior to the provision of further optometric care if the last complete vision analysis was performed more than two years before.

So what does this mean to you?

- Subjective:
  - personal and family medical history, personal and family ocular history, and chief complaint
- Objective:
  - VA (with and without at initial; with afterwards); pupils, EOMs, screening fields (*confrontation*), ocular balance (Cover test), refraction, SLE, tonometry (some method), fundus (dilation at first- disc, vessels, abnormalities), any and all others as dictated by exam
- Assessment- detailed
- Plan-detailed

Standards of Practice

(7)(a) To be in compliance with paragraph 64B13-3.007(2)(f), F.A.C., certified optometrists shall perform a dilated fundus examination during the patient's initial presentation, and thereafter, whenever medically indicated. If, in the certified optometrist's sound professional judgment, dilation is not performed because of the patient's age, physical limitations, or conditions, the reason(s) shall be noted in the patient's medical record.
(b) *Licensed optometrists* who determine that a dilated fundus examination is medically indicated shall advise the patient that such examination is medically necessary and shall refer the patient to a qualified health care professional for such examination to be performed. The licensed optometrist shall document the advice and referral in the patient's medical record.

Imaging of the fundus does not count.

What about non-Comprehensive exams?

- Whenever a patient presents to a licensed practitioner or certified optometrist with any of the following as the primary complaint, the performance of the minimum procedures set forth in subsection (2) above shall not be required.
- (a) Emergencies;
- (b) Trauma;
- (c) Infectious disease;
- (d) Allergies;
- (e) Toxicities; or
- (f) Inflammations.

- The minimum procedures set forth in subsection (2) above shall not be required in the following circumstances:
- (a) When a licensed practitioner or certified optometrist is providing specific optometric services on a secondary or tertiary basis in patient co-management with one or more health care practitioners skilled in the diagnosis and treatment of diseases of the human eye and licensed pursuant to Chapter 458, 459, or 463, Florida Statutes

So what does this mean to you?

- If you can't do a required test, state the reason and the attempt.
- Reason for this statute is to protect and provide to public quality care
  - Discourages 'refraction mills'
    - *"There is no reason that you cannot do an eye exam in less than 5 minutes"*

Branch License

- 2014- you no longer need to apply for branch licenses for each office
- You must however have a copy of your Florida license displayed in each office

120 South Monroe Street · Tallahassee, FL 32301
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FLORIDA OPTOMETRIC ASSOCIATION

Dispensing Optometrists

Florida Statutes, Section 463.0055, permits certified optometrists to administer and prescribe ocular pharmaceutical agents for the diagnosis and treatment of ocular conditions of the eye and its appendages.

Florida Statutes, Section 465.0276, permits registered practitioners authorized by law to prescribe drugs, including optometrists, to dispense such drugs to their patients in the regular course of their practice. This means that optometrists, as part of their practice, are allowed to sell the drugs they are permitted by law to prescribe. However, optometrists may not dispense any controlled substance listed in Schedule II or Schedule III, as provided in Florida Statutes, Section 893.03.

Drug Dispensing- For Profit

- A certified optometrist who dispenses medicinal drugs for a fee must register as a dispensing practitioner with the Florida Board of Optometry and pay a fee of $100.00 at the time of registration and upon each biennial renewal of licensure.
- Subject to and must comply with all laws and rules applicable to pharmacists and pharmacies
- Department of Health is authorized to inspect in the same manner and same frequency as it inspects pharmacies

Drug Dispensing- Samples

- Not required to register as a dispensing practitioner
- Must dispense the medicinal drugs in the manufacturer's labeled package with the practitioner's name, patient's name, and date dispensed.
- If not dispensed in the manufacturer's labeled package, they must bear the following information:
  - •Practitioner's name;
  - •Patient's name;
  - •Date dispensed;
  - •Name and strength of drug; and
  - •Directions for use.

US EYE

What can get you sued for malpractice and what can get you sanctioned by the Board of Optometry are often two different things

US EYE

The Board of Optometry does not involve itself in malpractice suits. Getting sued for malpractice does not get reported to the Board. The patient or other entity must file a separate grievance with the Board.

Bad Outcome vs Malpractice

US EYE

- Florida OD
- 60 YOBF
- Routine exam
- IOP: Upper 40's OU
- Glaucoma suspect
- Begins topical treatment
- Manages for 2 years
- IOP low to mid 20's

Bad Outcome vs Malpractice

US EYE

- Seeks care from ophthalmologist
- On multiple meds
- IOP mid 20's
- Meds changed
- IOP low 20's
- Undergoes ALTP, then trabeculectomy OU
- Sues optometrist
- Retained by patient's attorney

Bad Outcome vs Malpractice

US EYE

- Allegations:
- Detected elevated IOP and *only* used topical medications
- Diagnosed glaucoma, but failed to warn of serious nature
- Failed to diagnose optic nerve injury
- Failed to properly treat optic nerve injury
- Failed to refer to ophthalmologist

Bad Outcome vs Malpractice

US EYE

- Files:
- Medications obviously added, notations unclear
- No C/D ratio recorded for 1 ½ yrs
- Dilated exam performed, nothing recorded
- No gonio recorded
- No fields
- Frame style, bifocal style, seg height, PD, temple length, A/R coating, tint, all charges recorded
- Is this malpractice? Are allegations accurate?

Failure to Warn

- Consequences of contact lens use
  - Infectious Keratitis, overwear
- Consequences of spectacle wear
  - Breakage, polycarbonate, safety lenses
- Consequences of steroid use
  - Glaucoma, cataracts, superinfection

463.009 Supportive Personnel

- No person other than a licensed practitioner may engage in the practice of optometry as defined in s. 463.002(7). Except as provided in this section, under no circumstances shall nonlicensed supportive personnel be delegated diagnosis or treatment duties; however, such personnel may perform data gathering, preliminary testing, prescribed visual therapy, and related duties under the direct supervision of the licensed practitioner. Nonlicensed personnel, who need not be employees of the licensed practitioner, may perform ministerial duties, tasks, and functions assigned to them by and performed under the general supervision of a licensed practitioner, including obtaining information from consumers for the purpose of making appointments for the licensed practitioner. The licensed practitioner shall be responsible for all delegated acts performed by persons under her or his direct and general supervision.


FLORIDA OPTOMETRIC ASSOCIATION

Parental Consent Form

CONSENT TO PROVIDE HEALTH CARE SERVICES TO MINOR CHILD

I, _____ (parent or legal guardian), give written consent to _____ to arrange, schedule, and/or provide health care services, including the administration of topical anesthesia and prescription of medicinal drugs, to _____ (minor child), as deemed necessary for the health and welfare of said minor child. This authorization is effective from the date of signature.

Minor Child's Name _____ DOB: _____

Signature of Parent or Legal Guardian _____ Date _____

Relationship to Child _____

Known Drug Allergies: _____

Current Medications: _____

Primary Care Physician: _____

What happens when you get in trouble with the Board?

Case: Running afoul of a crazy person

- Visit 1: Older female presents for CEE
  - checks off on a questionnaire that she has cataracts, floaters, and dry eyes
  - does not check off or otherwise indicate eye pain, vision blur, vision loss or other symptoms
- Pt 'friends' with OD's parents- feels entitled to 'special treatment'
  - No waiting room or copays for her!
- OD flustered by pt 'barking' at her
- Performs IOP- normal, but not recorded

Case: Running afoul of a crazy person

- Successful dilation and stereoscopic evaluation of the optic nerves was performed and recorded as normal without suspicion of glaucoma. The patient was correctable to 20/20 in each eye following a thorough examination.

Case: Running afoul of a crazy person

- Pt returns 1 year for annual exam
- The patient does not complain of ocular pain or vision loss.
- Intraocular pressure by applanation is normal at this visit.
- A dilated fundus examination is successfully performed without precipitating an angle closure attack. There is no evidence of abnormality other than advancing age-appropriate cataracts

Case: Running afoul of a crazy person

- PT RTC 1 mos later complaining of blurred vision that had occurred 2 days previously, but had since resolved.
- The patient appears to have mentioned elevated blood pressure at this time.
- The anterior chamber was judged to be deep and quiet and the patient was successfully dilated again without precipitating an angle closure attack. No signs consistent with glaucoma were found upon examination.

Case: Running afoul of a crazy person

- Dr. diagnosed ocular surface abnormalities as a possible cause of the patient's transiently blurred vision and recommended lubrication as well as a referral to a primary care evaluation for a hypertension evaluation.
  - Pt diagnosed and now treated for HTN ☺
- PCP orders MRI to determine the cause of the patient's transiently obscured vision
  - MRI normal

Case: Running afoul of a crazy person

- 10 mos later, pt visits ophthalmologist who diagnoses 'narrow angle glaucoma'.
- MD examination details normal optic discs, normal retinal nerve fiber layer, and a normal GDx evaluation. Threshold perimetry done on this date also normal
  - Likely MD was using the antiquated term, "narrow angle glaucoma" to connote a potentially occludable angle.
    - Intraocular pressure at that visit was not in keeping with true angle closure.

Case: Running afoul of a crazy person

- Gonioscopy indicated potentially occludable angles and MD appropriately recommended laser iridotomy
  - Successful
- Interval of 10 months between the examinations
  - cataractogenesis process during this interval could easily increase pupil block and initiate narrowing of the anterior chamber angle, which may have not been present and observable to optometrist at the time of her last examination.

Case: Running afoul of a crazy person

- Pt quite agitated with optometrist for not 'diagnosing her glaucoma'
  - After all, pt needed surgery!
    - Prophylactic LPI
- Claims negligence against OD
  - Pain and suffering and mental anguish
    - Her life is 'ruined'
  - Negligent care
  - Misdiagnosis leads to vision loss
    - Nothing documentable

Case: Running afoul of a crazy person

- Pt claims she has sought counsel of several lawyers but doesn't 'want to go that way'
  - Translation:
- Pt send threatening letter to OD demanding refund of all fees, copays, and remuneration for 'pain and 'suffering' or she will 'avail herself of all legal means'
- Gives actual dollar amount for compensation
- Translation:
- OD seeks counsel
- Pt vindictively* reports OD to Board

* Personal editorial

Case: Running afoul of a crazy person

- Pt dilated twice- Stereoscopic disc analysis, BIO
- Pt treated appropriately for OSD, refractive error
- Pt referred for evaluation and diagnosed with HTN and treated
- *Sole issue: during 1 exam, under duress, OD did not record IOP*
  - OD admission- knew IOP could have been added and none of this would have happened, but knew it wasn't right thing to do
  - Did perform dilation and BIO and disc analysis at visit

Case: Running afoul of a crazy person

- Charge: Violation of Chapter 463.005 Rule 64B13-3.007 Minimum Procedures for Vision Analysis
  - Did not perform tonometry and 'specific glaucoma test'
- Board retains expert
- OD and attorney retain me as expert

The Facts as I See Them

- Tonometry is not, in fact, a "glaucoma test" or "specific glaucoma test", but merely the measurement of IOP
- Elevated intraocular pressure is a risk factor for glaucoma, but not in itself a diagnosis of glaucoma.
- Tonometry is not even an accepted screening test for glaucoma
  - Tonometry is not specific enough a test to screen for glaucoma as many patients with the disease can be mis-labeled as normal
- Detailed stereoscopic evaluation of the optic disc is a more sensitive measurement for the determination of glaucoma
  - Ergo, the OD *did* do a 'specific glaucoma test'

The Facts as I See Them

- No permanent damage sustained by the patient.
- No evidence that any of the patient's complaints were attributable to intermittent angle closure.
- The patient was determined to merely have potentially occludable angles.
- The patient successfully underwent laser iridotomy, which has presumably reduced the risk of future occlusion.

US EYE

The Facts as I See Them

- The same procedure would have been necessary had the potentially occludable state been diagnosed by any other qualified doctor at any time.
- Thus, the patient has received the proper treatment.
- There is nothing in any records reviewed that indicate the actions or alleged inactions of optometrist negatively impacted the apparently positive outcome for this patient.

US EYE

The Facts as I See Them

- OD delivered excellent care in face of adversity
- OD was professional in not altering record
- OD sought legal counsel

US EYE

Final Outcome

- Case dismissed for no probable cause

US EYE

Case: Alleged Negligence

- Lawn/tree service worker presents with corneal abrasion
  - No hx of vegetative matter given
  - 3 days of FB sensation; no complaints of vision loss
- Geographic abrasion and edema without infiltration
  - Treated with Maxitrol and bandage CL - f/u 2 days
    - RTC immediately if any changes
- Pt returns 2 days later with severe central corneal infiltration
- OD recognizes possibility of fungal infection - tries to refer immediately

US EYE

Case: Alleged Negligence

- Pt wants to 'wait to see if it gets better'
- Workers comp - referral authorization will take 'at least a week'
- OD adamant - explains fungal infection and permanent vision loss
- Pt ultimately referred and seen next day and treated for bacterial keratitis despite OD note about fungus
- After 7-10 days of not improving, pt referred elsewhere and dx'ed with fungal keratitis

US EYE

Case: Alleged Negligence

- Pt initiates litigation against OD
- Referral center recognized issue and offered compensation in advance of litigation, so was not sued
- Pt leaves country, not participating in legal process - case dies
- Pt's attorney vindictively* reports OD to DOH for license sanctions

*personal editorial

US EYE

Case: Alleged Negligence

- DOH Expert:
  - OD violated Chapter 463.0135(1) by failing to provide the degree of medical care provided by similarly trained medical practitioners in the same or similar communities
    - Treated corneal abrasion with antibiotic-steroid combination
      - Use of antibiotics alone is standard of care
    - Using steroid for vegetative corneal injury
    - Failed to timely refer fungal keratitis

US EYE

The Facts as I See Them

- No hx of vegetative injury ever given by pt to anyone
  - DOH broad speculation based upon employment and final diagnosis
- Steroid-antibiotic combo reasonable for corneal abrasion
- No indication of fungal keratitis at first visit
  - Prophylactic natamycin? Refer abrasion to corneal specialist? What more could OD do?
- OD was first to consider fungus, but nobody listened
- What would have happened if OD used standard of care treatment with topical antibiotics alone?

US EYE

Final Outcome

- Case dismissed for no probable cause

US EYE

"There is no bad referral?"

- OD sees patient with progressive vision loss after solar eclipse
- 20/50 vision OS
- Pt told had to see ophthalmologist STAT due to potential for blindness for "large cups in nerve"
  - 0.7/0.7 C/D OU
- On call ophthalmologist for ER reports OD for 'patient dumping'.

US EYE

Do as I say…or else

- Female presents to OD
- Demands 1 year refills on timolol
- Refuses any additional testing or follow up
- Doctor declines…gets reported to DOH

US EYE

Another RD Case

- Pt c/o floaters
- Examined by OD who dilates, performs BIO, finds retina intact, warns Si/Sx RD; RTC ASAP any changes
- Pt experiences vision reduction on a Thursday, somewhat worse on Friday- wants to see if it will 'clear up'
- Comes in Monday with macula off RD
- Sues OD
- Expert witness: "*He didn't look well enough*"
- Attorney invokes following statute:

Another RD Case

- (4) A licensed practitioner shall promptly advise a patient to seek evaluation by a physician skilled in diseases of the eye and licensed under chapter 458 or chapter 459 for diagnosis and possible treatment whenever the licensed practitioner is informed by the patient of the sudden onset of spots or "floaters" with loss of all or part of the visual field.
- Defense attorney flustered by rule
  - Retained to defend OD

Why is this so?

- Do I have to refer every case of flashes and floaters?
- Difference between licensed practitioner (who cannot dilate) and certified practitioner (who can dilate).
- These patients need dilation- licensed practitioner can't and certified can.
  - If RD found- pt logically referred
  - If nothing seen but pt has vision loss- pt logically referred
- Why no statute regarding older patient with headache and jaw claudication, etc?

Standards of Practice

- (2) A licensed practitioner diagnosing angle closure, infantile, or congenital forms of glaucoma shall refer the patient to a physician skilled in diseases of the eye and licensed under chapter 458 or chapter 459.

Why is this so?

- Acute angle closure, infantile, and congenital forms of glaucoma are primarily surgical diseases.
- Forces non-surgeons from "Forrest Gumping their way through" medically

Responsibility

A licensed practitioner shall have an established procedure appropriate for the provision of eye care to his/her patients in the event of an emergency outside of normal professional hours, and when the licensed practitioner is not personally available. Since the licensed practitioner's continuing responsibility to the patient is of a personal professional nature, no licensed practitioner shall primarily rely upon a hospital emergency room as a means of discharging this responsibility.

So what does this mean to you?

- Unlike every other medical provider, your answering machine cannot say, "*If this is a medical emergency, hang up and dial 911*"
- You must have an on-call system after hours; The system cannot direct patients to the ER.
- Options: your cell phone #, professional answering service with your cell phone #; a colleague or practice/ institution who will accept your emergencies
- Note: you have no obligation to provide after hours emergency care to any person who is NOT your patient
  - Caveat: neither does your ophthalmology colleagues

US EYE

- (3) When an infectious corneal disease condition has not responded to standard methods of treatment within the scope of optometric practice, the certified optometrist shall consult with a physician skilled in diseases of the eye and licensed under chapter 458 or chapter 459.

US EYE

So what does this mean to you?

- Duh!
- Do we really have to explain it?

US EYE

64B13-3.010 Standards of Practice.

(4) Certified optometrists employing the topical ocular pharmaceuticals listed in subsection 64B13-18.002(9), F.A.C., Anti-Glaucoma Agents, shall comply with the following:

(a) Upon initial diagnosis of glaucoma of a type other than those specifically listed in Section 463.0135(2), F.S., the certified optometrist shall develop a plan of treatment and management.

1. The plan will be predicated upon the severity of the existing optic nerve damage, the intraocular pressure, and stability of the clinical course.

In the event the certified optometrist cannot otherwise comply with the requirements of subsections 64B13-3.010(1)-(3), F.A.C., a co-management plan shall be established with a physician skilled in the diseases of the human eye and licensed under Chapter 458 or 459, F.S.

US EYE

So what does this mean to you?

- Not much different than what you are already doing.
- If you diagnose glaucoma, make a treatment plan
- If glaucoma is bad, make it an aggressive plan.
- If you can't, send it to someone who can

US EYE

Standards of Practice

(b) Because topical beta-blockers have potential systemic side effects a certified optometrist employing beta-blockers shall, in a manner consistent with Section 463.0135(1), F.S., ascertain the risk of systemic side effects through either a case history that complies with paragraph 64B13-3.007(2)(a), F.A.C., or by communicating with the patient's primary care physician. The certified optometrist shall also communicate with the patient's primary care physician, or with a physician skilled in diseases of the eye and licensed under Chapter 458 or 459, F.S., when, in the professional judgment of the certified optometrist, it is medically appropriate to do so. This communication shall be noted in the patient's permanent record. The methodology of communication is left to the professional discretion of the certified optometrist.

US EYE

So what does this mean to you?

- When in doubt…ask
- You are not obligated to tell the PCP that you have prescribed a beta blocker…but it is good care and a courtesy
- Easy way- write the Rx and tell the patient to show to PCP before filling.

Standards of (Glaucoma) Practice

(c) The certified optometrist shall have available, and be proficient in the use of, the following instrumentation:
1. Goldman-type applanation tonometer.
2. Visual fields instrumentation capable of threshold perimetry.
3. Gonioscope.
4. Fundus Camera or detailed sketch of optic nerve head.
5. Biomicroscope.
6. A device to provide stereoscopic view of optic nerve.

Hmmm… still no pachymeter, camera, or OCT

- (9) A licensed practitioner who believes a patient may have glaucoma shall promptly advise the patient of the serious nature of glaucoma. The licensed practitioner shall place in the patient's permanent record that the practitioner provided such advice to the patient.

Responsibility

Patient records shall clearly identify the optometrist who examined or treated the patient on each separate occasion.

So what does this mean to you?

- Sign the chart
- Make sure EHR drops signature correctly
- This has been an issue in Board cases and malpractice litigation

Patient Records

64B13-3.003 Patient Records; Transfer or Death of Licensed Practitioner.
(1) The licensed practitioner must legibly sign the entry in his or her records for each patient encounter. If the practitioner maintains electronic patient records, the practitioner may affix an electronic signature which can be generated by using either public key infrastructure or signature dynamics technology, and meets the following criteria:
(a) The electronic signature is unique to the person using it;
(b) The electronic signature is capable of verification;
(c) The electronic signature is under the sole control of the person using it;
(d) The electronic signature is linked to the record in such a manner that the electronic signature is invalidated if any data in the record are changed.

Patient Records

(2) A licensed practitioner shall maintain full and independent responsibility and control over all records relating to his or her patients and his or her optometric practice. All such records shall remain confidential except as otherwise provided by law and shall be maintained by the licensed practitioner in compliance with Rule 64B13-3.001, F.A.C. For the purposes of this rule, "maintain full and independent responsibility and control" means that the records shall be maintained in the licensed practitioner's office or solely in the possession of the licensed practitioner, and that the licensed practitioner shall not share, delegate, or relinquish either possession of the records or his or her responsibility or control over those records with or to any entity which is not itself a licensed practitioner.

US EYE

Patient Records

(3) The records relating to the patients of a multidisciplinary group of licensed health care professionals as provided in Section 463.014(1)(a), F.S., or relating to the patients of a partnership or professional association as provided in Section 463.014(1)(b), F.S., may be maintained by the group practice, partnership, or professional association on behalf of all licensed practitioners employed by the group practice, partnership, or professional association.

(4) For the purposes of this rule, "entity which itself is not a licensed practitioner" shall refer to any corporation, lay body, organization, individual, or commercial or mercantile establishment which is not a licensed practitioner or which is not comprised solely of licensed health care professionals, the primary objective of whom is the diagnosis and treatment of the human body.

US EYE

Patient Records

(5) For the purposes of this rule, "commercial or mercantile establishment" shall include an establishment in which the practice of opticianry is conducted pursuant to Chapter 484, Part I, Florida Statutes, and an establishment in which optical goods are sold.

(6) A licensed practitioner shall keep patient records for a period of at least five years after the last entry. Upon the discontinuance of his or her practice, the licensed practitioner shall either transfer all patient records which are less than five years old to an eye care practitioner licensed pursuant to Chapter 463, 458, or 459, F.S., where they may be obtained by patients, or he or she shall keep them in his or her possession for at least five years and make them available to be obtained by patients.

US EYE

So what does this mean to you?

- The records are yours, not the optician's, not Lenscrafters, etc.
- Keep them for 5 years after last visit
- Hand them off to a colleague if pt active and records less than 5 years old

US EYE
BETTER TOGETHER

Sample title

- Content 1
  - Item 1
- Content 2
  - Item 2

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