American Academy of Ophthalmology
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Opinion

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How Comanagement Is Really No Management

Optometrists often receive a fee of several hundred dollars. Ophthalmologists receive nearly the same. In the past, it was called fee splitting and was frowned on by the American Medical Association and individual physicians. It was against our code of ethics. Now it is called comanagement.

Comanagement with nonphysicians has become more common following cataract and refractive surgery. You don't have to be a rocket scientist-or an ophthalmologist, for that matter-to determine whether something has gone horribly wrong with either of these procedures. The eye lets you know. We are told one of the reasons comanagement, especially following cataract and refractive surgery, is popular is that complications from these procedures are comparatively uncommon. In effect most of the time the "patient finder fee" or fee-splitting arrangement called comanagement is associated with little or "no management." It is a consequence of the trivialization of highly successful and technologically advanced surgical procedures.

The optometrist following the patient seldom needs to do more than identify disasters. Sadly many are unable to recognize the rare and subtler early signs of endophthalmitis, which if treated effectively would be a great service. When disaster strikes, the patient is returned to the surgeon.

Rarely, if ever, does a malpractice suit involve the optometrist. According to the Ophthalmic Mutual Insurance Company (OMIC), no suits have arisen among its members because of comanagement. Nevertheless, it

recommends using explicit forms confirming in writing the postoperative shared- management arrangement for each patient.

The comanagement fee for optometrists of $400 to $950 for LASIK is disproportionately high considering the service rendered. Is it any wonder that many regard the fee as a "pay back" for the referral? Nor is it any wonder that ophthalmologists who refuse to participate in this form of legalized fee splitting are ostracized by referring optometrists? What value do patients derive from the fee they pay?

Except in emergency situations when the physician is indisposed patients should be informed prior to surgery who will be responsible for their care and what his or her qualifications are. Furthermore, according to Rule 8 of the American Academy of Ophthalmology Code of Ethics, the patient must be informed beforehand of the effect of the postoperative care arrangements on the fees for services.

This isn't to say there aren't appropriate circumstances for shared-management. This sort of arrangement works brilliantly in underserved areas- for instance, rural communities. In this setting, local practitioners can team with out-of-town colleagues to extend care.

In recent years, in a minority of practices, an associate may only be involved in the pre- and postoperative management of patients. It is argued that this offers patients the best technical and medical care while providing the most efficient use of practice resources.

During the past year, I have received a number of letters decrying a new practice, the establishment of comanagement refractive surgery in academic ophthalmology programs with local optometrists. Academic centers faced with Physician At Teaching Hospital audits, so-called PATH audits, tighter regulations and increased competition, are fighting for survival like other ophthalmologists. Some have hired optometrists to foster referrals from outside optometrists. In some instances, comanagement occurs within the institution not only among ophthalmologists, but among ophthalmologists and optometrists who screen patients, perform preoperative evaluations and follow patients postoperatively. This causes many members grave disappointment because they view academic centers as our "moral compass." For others it is viewed when performed within state-supported institutions to be unfair competition.

How long will it be before optometrists "comanaging" surgical cases argue that they have gained insight and experience in postoperative management not available yet in schools of optometry and that refractive surgery is so

automated that they should be allowed to do it as well? State legislators and the public will have great difficulty distinguishing the difference between ophthalmologists and optometrists. When this happens, we will have no one to blame but ourselves.

The ophthalmologist's duties concerning postoperative care are succinctly outlined in Academy Policy Statements and the Code of Ethics. Whether you participate in comanagement or shared-management of patients with another ophthalmologist or a nonophthalmologist these documents are well worth reading. As physicians, our guiding principle must always be to do what is in the best interest of patients.

What do you think about this? Let us know.

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