Letters

Medicolegal and Ethical Lessons From the Pandemic

The COVID-19 pandemic has made ophthalmologists re-examine their priorities and perspectives. As a vitreoretinal surgeon, I teamed up with a medical ethicist, John D. Banja, PhD, at the Emory University Center for Ethics, and an Atlanta-based medical malpractice defense attorney, Anna B. Fretwell, JD, at Huff Powell Bailey. We discussed the challenges faced and the lessons learned by ophthalmologists during the pandemic.

During the lockdown, many ophthalmologists encountered dilemmas, including how to manage patients who need ongoing care or experience urgent eye problems when our offices are closed, or how to provide urgent treatments when resources, such as personal protective equipment (PPE) or OR availability, are limited.

The American Medical Association's ethical codes generally require health care professionals to prioritize their patients' welfare over their own.[1] That would mean treating COVID patients even when the personal risk is high (e.g., when PPE is in short supply). From a medicolegal perspective, malpractice liability may be incurred when care is delivered outside of the usual parameters. During this unprecedented time, this has been happening due to resource constraints, such as office closures or lack of OR access.

While federal and state immunity laws may offer some protection (the scope of which may vary),[2] we think that providing care by putting patients' interests first and by following ethical principles is still the best way to limit liability. Guiding principles include:

1. Provide clear communication with patients regarding diagnosis, prognosis, and treatment options. The patient's consent is essential in establishing trust and minimizing future liability claims. Setting and gauging a patient's expectations to ensure that they align with yours is essential to avoid disappointment.

2. Maintain contemporaneous documentation of care, including any departures from typical practice and the reasons for the deviation. If the appropriateness of the care is challenged at a later time, good documentation would help support the reasonableness of those changes. For example, if I decide not to give an injection to a wet AMD patient as scheduled after determining from a phone call that his subjective vision is stable, I might postpone his visit—if the patient agrees. I would then document the reasoning in the chart.

It's a balancing act that physicians do every day: Our patient's best interests, the health and safety of our care team, and other patients' welfare—they all need to be considered to make the best possible decisions.

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1 AMA Code of Medical Ethics. www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/principles-of-medical-ethics.pdf. Accessed Feb. 2, 2021.
2 Klitzman RL. *Chest.* 2020;158(4):1343-1345.

CORRECTIONS. *EyeNet* regrets the following errors.

In "Biosimilars in Ophthalmology," (cover story, January), *EyeNet* incorrectly stated on page 41 that the biosimilar Razumab had been approved by the FDA and the European Medicines Agency. It had not been approved by either agency. The online version of the article at aao.org/eyenet/archive removes mention of these approvals.

In "Volunteer Opportunity: Help Diversify Ophthalmology" (Notebook, February), *EyeNet* incorrectly stated that the Minority Ophthalmology Mentoring program deadline is July 15. The online version of this article at aao.org/eyenet/archive states the correct deadline, June 15, with an opportunity for an early decision deadline on April 12.