TECHNIQUES FOR SUCCESSFUL REATTACHMENT

Reconnecting ophthalmology to the larger medical world after COVID-19.

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As the national and international consequences of COVID-19 continue to unfold, ophthalmologists find themselves in a particularly unique position. Our daily work of reaffixing falling retinas, protecting ganglion cells, and salvaging traumatized eyes undoubtedly saves patients from irreversible blindness and its tragic social, economic, and physical consequences. Timely recognition of uveitis, retinal emboli, or orbital tumors may even save lives. As elective surgeries are put on hold, many ophthalmologists must continue to operate because, often, what requires our expertise simply cannot wait.

But we also now live in a world in which medical professionals and the general public alike know far more than they ever expected to know about N95 masks, ventilators, and acute respiratory distress syndrome. As the numbers of infected patients swell and health systems groan under the strain of critically ill patients, many physicians are assuming clinical responsibilities outside their usual scope of practice.[1] In areas heavily affected by the virus, ophthalmologists are being asked to work on medical floors and in emergency departments.[2] For many, that prospect is alarming.

We are primarily outpatient specialists who, in contrast to almost every other medical specialty, can provide faster and better care when we have access to office-based equipment, such as slit lamps, OCT platforms, and fundus cameras.[3] As surgical techniques have advanced, the need for inpatient surgery has diminished.[4] Accordingly, our cross-specialty collaborations have shifted from in-person interactions to templated letters autogenerated by our electronic health record systems. Ophthalmologists have gradually, perhaps inevitably, drifted away from the general medical milieu. Now, we have abruptly been yanked back into this unfamiliar world.

We now confront the reality that ophthalmologists cannot afford to be so detached from general medicine; fortunately, there are several strategies for reattaching ourselves to the medical family. (Puns absolutely intended.)

STRATEGY NO. 1. REMEMBER YOUR TRAINING

First, recognize that we are, in fact, medical doctors who went to medical school and learned about endometriosis, otitis media, and the coagulation cascade. This ethos should permeate ophthalmology training. There is a movement toward integrated ophthalmology residencies, wherein part of the intern year is dedicated to "getting up to speed" for the dedicated ophthalmology years to come.[5] After all, it is often rhetorically asked, "How many asthma exacerbations do you have to manage to be a good ophthalmologist?" In 2020, the answer may be "more than you think."

As we contemplate how to cram an ever-expanding ophthalmology knowledge base into 3 years of postgraduate training, we should remain mindful of the balance that we are physicians specializing in eyes, not simply "eye doctors." The purpose of the heart, it turns out, goes beyond perfusing the retina. With that in mind, a few seconds of extra attention to general examination of our patients might reveal a shuffling gait, psychomotor retardation, actinic keratosis, or any number of conditions amenable to early diagnosis and management.

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STRATEGY NO. 2. COMMUNICATE BETTER WITH OTHER DISCIPLINES

We must also rethink how we interact with other medical specialties. Ophthalmologists are notorious for their alphabet soup vocabulary, which has served as fodder for a number of satirical articles.[6,7] In our busy clinics, abbreviations are crucial for concisely conveying important medical information. However, in the era of electronic health records, it is a simple matter of motivation to autoexpand abbreviations or include helpful smart phrases, at least for our patients for whom coordination of multispecialty care is particularly important. For example, "Macular imaging reveals early retinal changes that are concerning for hydroxychloroquine toxicity. Will coordinate with Dr. Garcia (rheumatology) to see if this can be safely discontinued," is infinitely more helpful—and respectful—than "OCT w EZ abnl, DFE mild RPE ch, d/c HCQ."

We can further address this issue by simply picking up the phone and consulting with primary care physicians, endocrinologists, and rheumatologists, much as we do with our colleagues in other ophthalmic subspecialties.

Moreover, ophthalmologists routinely educate their patients on incredibly complex topics. There is an art to precisely explaining a posterior vitreous detachment. Why not take a few minutes to do the same for our medical colleagues, be it an ad hoc conversation or the occasional webinar or dinner? We similarly stand to learn from other physicians in such interactive, interdisciplinary venues.

STRATEGY NO. 3. LOOK AT THE BIGGER PICTURE

Finally, we must also appreciate our role within the larger context of medicine. We will never be expert inpatient physicians, nor should we strive to be. We can, however, assume the mantle of keeping our sick, elderly, and vulnerable patients out of hospitals, freeing up resources for more systemically ill patients and protecting our patients from potential iatrogenic complications. In the short term, this means pushing through the growing pains as the logistics of telemedicine's use in ophthalmic disease are further clarified. By any account, a virtual visit in which the risk-benefit ratio of a penetrating keratoplasty in a functional 80-year-old vasculopathic patient with 20/30 vision in her other eye is thoroughly discussed, and unnecessary intubation avoided, is a win for the patient and the health care system.

It may behoove us to unlock our clinics after hours for the patient with a sudden visual field defect instead of directing him or her to the emergency room via ambulance, or to work in the same-day patient with a doesn't-sound-like-my-subspecialty eye problem from the primary care office across the street.

CONCLUSION

This year, 2020, was foreseen by many to be the "Year of the Ophthalmologist." (Again, pun intended.) However, it is hard to realize this vision in a world so fundamentally disrupted by COVID-19. But, as with so many other aspects of our society, this pandemic has offered an opportunity for us to introspect, transform, and grow. There is no denying that we are trained specialists who perform life-changing work. In 2020, we can bring those skills and knowledge back into the fold of the family of medicine. ■

The views and opinions expressed are those of the author and do not necessarily reflect the official policy or position of organizations with which the author may be affiliated.

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