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## How Surgeons Manage Comanagement

**Though comanagement works for some surgeons, many physicians find it to be a negative aspect of practicing ophthalmology.**

*Walter Bethke, Managing Editor*

**It's possible that the opinion of our national panelists** on the topic of comanagement may have deteriorated since the last time they weighed in back in 2002. Fewer of them approve of it now, and more say that the practice of inducing comanagement through financial incentive is worse than ever. Comanagement does work for some physicians, however—some of whom practice in rural, underserved areas. In this month's National Panel Report, our panelists share their thoughts about this hot-button topic.

For this survey, 83 panelists, or 17 percent of our 500-surgeon sample responded. To compare their feelings about the practice of comanagement with yours, read on.

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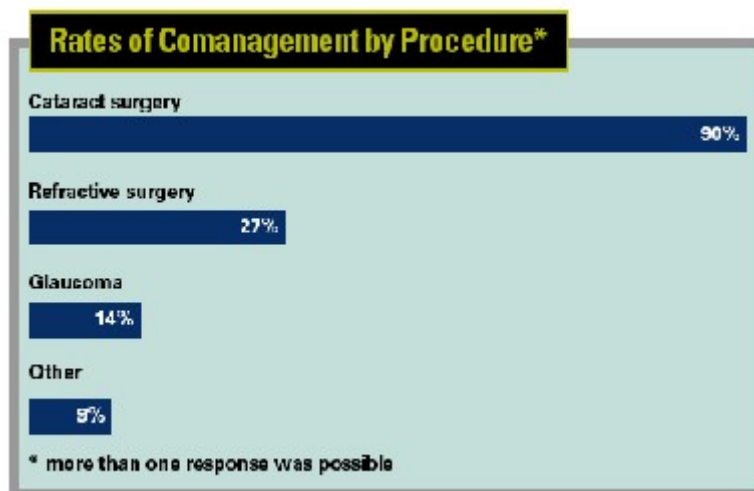


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### Comanagement's Prevalence

In this year's survey, 27 percent of surgeons say they comanage patients with optometrists. Of these, 91 percent comanage cataract cases, 27 percent comanage refractive-surgery patients and 14 percent comanage glaucoma cases. Some surgeons chose more than one answer.



As in years past, the most popular reasons surgeons give for comanagement center on access to medical care for patients in relatively remote areas.

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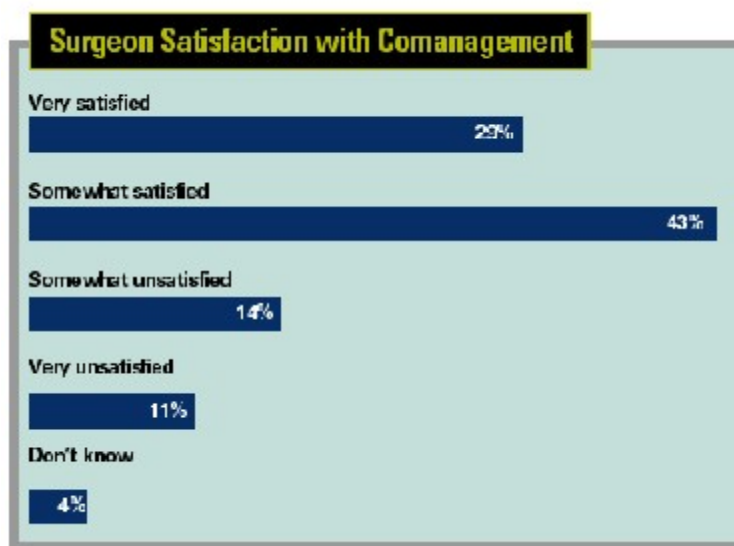
“We have a low population density,” states a surgeon from Indiana. “We also have a wide geographic distribution of patients. It gives these patients the convenience of more local follow-up.”

A surgeon from Montana is in the same boat. “For some patients, it is convenient,” he says. “Much of Montana is rural.”

“Comanagement is convenient, patients like it, the care is very good, and the ODs are happy,” explains a doctor from Arkansas.

Panelists also held forth on two aspects of their comanagement arrangements:

- **Overall satisfaction.** Three years ago, 36 percent of surgeons said they were very satisfied with their comanagement arrangement; now only 29 percent say the same. Also, more surgeons now (43 percent) say they are only somewhat satisfied with their arrangement, compared to last survey’s 26 percent. Today, 14 percent say they’re somewhat unsatisfied (compared to just 7 percent in 2002) and 11 percent say they’re very unsatisfied, vs. 7 percent three years ago.



In these arrangements, 85 percent of the surgeons say they either meet or examine the comanaged patients before their surgeries, while 15 percent don't. Similar to the 2002 survey, 58 percent of surgeons release the patient back to his optometrist after a month of postop visits, while the rest do so after the first postop exam.

- **Optometrists' follow-up skills.** Surgeons rated their comanaging optometrists' skills in three areas: consistency of follow-up; the ability to recognize and manage complications; and the ability to handle patient confusion regarding payments. Of these, the biggest change between 2002 and today occurred in the second rating area. Though the percentage of surgeons who rate their optometrists as “good” at recognizing and managing complications increased from 28 percent in 2002 to 44 percent now, the percentage who rate them as “excellent” dropped from 17 percent to 9 percent.

Fifty-seven percent of the surgeons say they take steps to confirm a comanaging optometrist's training and/or ability.

A surgeon from Indiana says he confirms his optometrist's training by “sharing non-comanaged patients at first, as well as reviewing education and experience.”

An Arkansas ophthalmologist says he verifies an OD's ability by getting to know him personally, "and seeing patients at eight weeks postop."

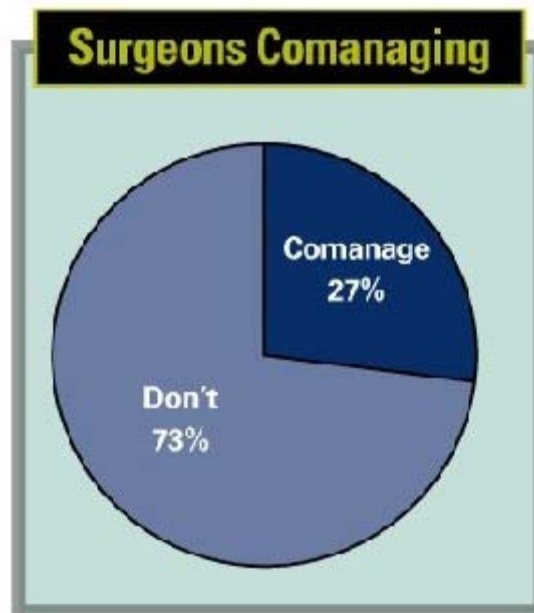
A surgeon from Utah says he "rechecks [the optometrist's] refractions [daily] and finds out more about his previous experience."

"I work with them in their clinics," avers an ophthalmologist from Mississippi.

Michael Solomon, DO, from Warren, Mich., reminds surgeons that asking about a comanaging optometrist's skills may still not paint the whole picture. He says he took steps to confirm an OD's skill before he started comanaging patients with him, but "the individual unscrupulously misrepresented himself." He says this is part of the reason why he is now "hesitant to seek any further comanagement relationship."

### Comanagement's Detractors

Though comanagement works for some surgeons, many respondents don't think very highly of it. Similar to the outcome of our 2002 survey, most of panelists, 73 percent, don't comanage patients with optometrists. Many take issue with optometrists' skill in managing patients, while others characterize comanagement as an unethical splitting of fees.



"I don't feel that optometrists are trained adequately," says a physician from Pennsylvania. "It's not ethical." She says she has "already seen mistakes in their diagnoses of relatively simple problems and poor decision making in prescribing."

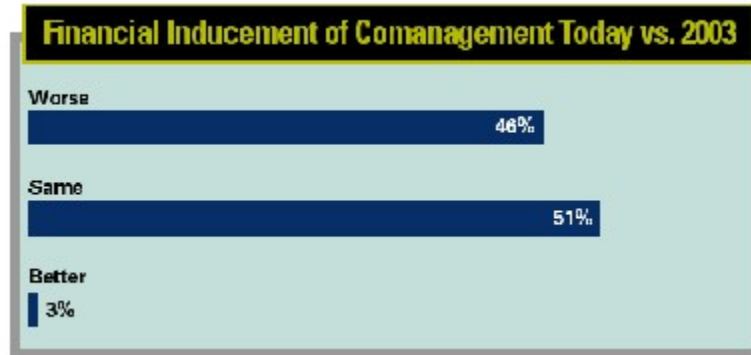
"After observing my optometric colleagues for over 20 years," says a surgeon from Ohio, "I do not feel they are competent to follow surgical patients."

An ophthalmologist from Nebraska says he doesn't engage in comanagement because, "It's my practice philosophy that the surgeon should manage surgical patients."

"Comanagement is legalized fee-splitting!" asserts Joel Gottlieb, MD, of Succasunna, N.J.

Ronald May, MD, of Deerfield, Ill., doesn't put much stock in comanagement, either. "It's my responsibility to follow patients postoperatively," he opines. "Plus, [optometrists] are not competent enough to do so."

"Comanagement is an unethical, self-serving rebate," says a physician from California.



Another surgeon from California has had enough bad experiences to become sour on comanagement. "We have seen nothing but abusive comanagement arrangements which truly compromise the level of patient care and safety," he says. "They are motivated by business and have actually resulted in bidding wars." In his "heavily doctored" region, he says there's no legitimate need for comanagement.

**Optometric Scope of Practice**

also asked surgeons to what extent optometrists should be allowed to expand their scope of practice into the realm of surgery. None of the panelists think optometrists should be allowed to do surgery of any kind, including retinal and glaucoma laser procedures.

An Ohio surgeon says optometrists shouldn't be allowed to expand into surgery because "they don't have the knowledge."

A Nebraska physician is equally dubious about allowing optometrists to perform surgery. "They are not trained as surgeons—they can go to medical school and enter ophthalmology if they so desire."

Surgeons Rate Optometrists' Skills					
	Excellent=1	Good=2	Fair=3	Poor=4	Mean
Consistency of follow-up	26%	47%	22%	4%	2
Ability to recognize and manage complications	8%	43%	39%	8%	2.5
Handling patients'					

confusion regarding payments	14%	52%	19%	14%	2.3
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Richard Bensinger, MD, of Seattle, agrees. They have “woefully inadequate training,” he says. He adds, “A little knowledge is potentially dangerous. ODs know some things. I always compare their training to ours as legal assistant vs. lawyer. But, let’s face it, 90 percent of [diagnoses] are obvious, and that’s not where the public health issues lie. It’s the 10 percent that is beyond them that’s the problem. They do not want to refer to MDs for fear of losing face. It is a terrible fraud upon the public.”

“The route [to surgery] is medical school, an ophthalmology residency, acquiring competence, then surgery,” says Illinois’ Dr. May.

A Californian agrees, saying, “Optometric expansion into surgery is dangerous. They have a very superficial knowledge, and couldn’t pass any MD exams.”

“If you can create a surgeon by legislative fiat, then let them all be neurosurgeons—we need more of those!” quips Paul Rentiers, MD, of Houston.

### Comanagement Legislation

Though some respondents (20 percent) think lobbying for comanagement legislation is a good idea in order to set comanagement’s boundaries, the rest don’t approve of lobbying efforts, saying, in effect, that such activity legitimizes the practice too much.

“It sends the wrong message,” says Seattle’s Dr. Bensinger.

“We should lobby against it,” says a California surgeon, “except in cases with certain explicit circumstances.” Dr. Gottlieb concurs, saying, “Comanagement is a bad idea. There should be legislation against it.”

Boonlua Ratanawongsa, MD, of Olean, N.Y., supports legislation if it is aimed at helping comanaged patients. “The physician should follow the patient until it’s safe enough to refer him back to the optometrist, probably for at least three weeks.”

An Iowa physician also thinks legislation is the way to control comanagement. “It needs to be tightly controlled to level the playing field and protect patients,” he says.

A surgeon from Virginia, however, isn’t concerned about the state of comanagement legislation, and says that he’s satisfied with his comanagement arrangement. When asked why, he simply replies, “Because I don’t comanage.”

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