Tough Talks and Patient Privacy

By Dr. Ryan Anderson

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Decisions are made every day in regard to patient care in optometry. Most are easy, but some require a bit more deliberation involving ethical considerations and ultimately the patient's best interest. During my rotation at Midwestern University Eye Institute, I encountered a patient who was a relative of another optometry student in my program. The patient was a 26-year-old healthy, white male with no significant ocular history other than LASIK surgery years prior; he reported compliance with yearly routine eye examinations. He presented with the complaint of acute onset scotoma in the left eye status post a "cold" two weeks prior. His systemic health was unremarkable. He was able to locate his blind spot and felt this was a new area of vision loss. Upon examination, he was 20/20 in each eye distance and near. Preliminary testing was normal; there was no afferent pupillary defect. Refraction was deferred. Anterior segment examination revealed no abnormal findings, but the patient did note that the slit lamp light was partially missing when I held it just temporal to his visual axis. After dilating, I found a single cotton wool spot (CWS) temporal to his macula (about equidistant between the fovea and optic nerve in the left eye). It was approximately 0.5 mm in size with distinct margins and round. Additional testing to further investigate this spot, including macular OCT, central visual field, fundus photo, Amsler grid and Watzke-Allen tests, was completed. All tests indicated a definite and well-defined area of visual field loss temporal to his visual axis consistent with his chief complaint. Fundus photos and OCT documented the CWS, which was correspondent in location with the area of field loss. The spot was affecting the sensory retina all the way into the deeper layers, which was

slightly different in the appearance of a typical CWS. My preceptor and I advised him to pursue serology to evaluate for a systemic etiology. A complete blood cell count with differential for gross hematologic abnormality or cancer, fasting blood glucose for diabetes, and a complete metabolic panel for other systemic problems was obtained. We did not expect any of these tests to come back positive for any disease but it was our responsibility to at least rule out potential systemic causes. There are other causes worth ruling out including HIV/AIDS or sexually transmitted diseases. These diseases can also be transmitted via intravenous drug use. However, our patient was of Mormon faith and known to not associate with these activities. It was still a conversation we, as health professionals, were obligated to have regarding whether he had engaged in any of these activities to warrant testing for these diseases. He denied participation so we educated him on the importance of ruling out those diseases should there be any possibility he could have contracted them, but we were comfortable not including them in our battery of initial tests.

We had a discussion with the patient pertaining to how far we wanted to take the testing. Since it presented as a single isolated spot, it was likely to be a rare complication of the recent viral infection from a common cold that had since resolved. If that was the case, further testing would come back negative. We also considered the financial burden to the patient as these tests are costly. On the other hand, if this patient was really concerned about narrowing it down at the very least, it wouldn't be unnecessary to test for as many potential causes as the lab had to offer. The patient expressed understanding and left the clinic to obtain the testing immediately. He was scheduled to return in six weeks, which is the approximate amount of time it should take for a CWS to disappear completely helping to confirm our diagnosis.

After he left the clinic, I was contacted by his relative in my optometry class who was understandably eager to see the photos and OCT images. I had not thought to have our patient sign a release before he left so I may divulge all the information we had acquired in the exam. I was at a dilemma of simply talking to him about the exam since I am good friends with him. I knew my patient wouldn't mind and might even prefer we discussed it with his relative; however, I decided it was best to have the patient

return to sign a release for his records before I discussed any exam information. It was definitely an inconvenience, but I decided no matter how much you think you know about a situation, it only takes one misreading of someone's personality to violate HIPAA laws and seriously harm your career because of it. All in all, I feel it was the right decision and both the patient and his relative understood.

At his follow-up appointment, my patient still had the loss of vision, but his CWS was gone. All of his lab testing was negative, and we ultimately left it up to him to decide on further testing. We discussed with him our thoughts on the situation regarding his lifestyle and explained his problem was likely due to a rare opportunistic infectious process as he was sick two weeks prior to noticing the blind spot. We reinforced that if he wanted to pursue further testing, we would be happy to order the tests and direct him where to go. After everything, he decided he was fine without the additional testing and just monitoring it. It was an interesting case that brought up some tough conversations, but, all in all, patient safety and patient information laws were accurately followed.

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