Letters

Monitored Anesthesia Care in Cataract Surgery

Anthem BlueCross BlueShield recently announced guidance to deny coverage for monitored anesthesia care (MAC) for cataract surgery. They also sent notification to their providers that they don't believe that MAC provided by anesthesia personnel is warranted in the vast majority of cataract procedures given the overall safety of the procedure, and they refer to only 1 article[1] published in a scientific journal in support of this decision.

I am the senior author of this article and wish to set the record straight, as they have misinterpreted our findings and made statements that are directly contrary to our conclusions and to those of Randall J. Olson, MD, the paper's discussant.

Our paper states, "In 1,006 consecutive cataract surgery cases, intervention by anesthesia personnel was required in 376 (37.4%) of cases. No preoperative characteristics were found to be reliable predictors of the need for intervention." Certain subgroups of patients were significantly more likely to need intervention, including those with systemic hypertension and pulmonary disease, and those under age 60. We concluded, "Because intervention is required in more than 1/3 of cataract surgery cases and the authors cannot reliably predict those patients at risk, monitored anesthesia care seems justified in cataract surgery with the patient under local anesthesia."

These results may be tempered by the fact that more cases are now done under topical anesthesia than peribulbar anesthesia, and 19 years have elapsed since the study was performed. Nonetheless, until such time that there is scientific evidence to support claims to the contrary, we still believe that decisions regarding the advisability of MAC in cataract surgery should be made by the surgeon in consultation with the patient and family. How can the ophthalmic surgeon be expected to adequately monitor his or her patient while concentrating on performing intricate surgery? In the event of an intraoperative problem, anesthesia personnel are far better qualified to intervene than ophthalmologists are.

We do not recommend putting patients at risk for the potential cost savings.

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1 Rosenfeld SI et al. *Ophthalmology.* 1999;106(7):1256-1261.

From the editors: At time of press, the Academy's advocacy team was continuing direct discussions with Anthem to secure immediate reversal of its guidance on monitored anesthesia during cataract surgery.

On Practicing "Part Time"

Thank you, Ruth, for the wonderful editorial "Can You Practice Part Time?" (Opinion, January). I fought throughout my career to establish work/home life balance. This was a particularly difficult battle in the bastions of academia in the 1990s. In the early '90s, when I decreased my clinical days to 60% full-time equivalent, I was deemed part time even though I was 40% grant funded. I was told that I would not be taken seriously in academia if I stayed part time and I would not be promoted. In fact, I was promoted in the clinician scientist research track on schedule at a time when few were achieving their promotions on this track. I chose to leave the university after 14 years, however, since my "part-time" status was not supported by my chair and I was constantly pressured to return to 5 days of clinical practice. It is so important to live the life you want to live—we can easily remain committed, dedicated, effective physicians working fewer than 5 days a week!

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A Response to the Academy's 2018 President

Dr. Keith Carter's editorial "The Value of Education, and the Satisfaction of Giving Back" (President's Statement, January) is inspirational and aspirational. The Academy's mission to protect sight and empower lives goes hand in hand with his goals.

First, improving the language of our computerized systems will help improve care of our patients. Second, Dr. Carter has been an innovator in educational efforts, and it is clear that his ideas will also improve the training of our future colleagues. Finally, diversity is critically important but often misunderstood. We have known for years that a diverse workforce improves the questions we ask in research and the care we give to the population, and it is a core strategy of medical schools and health systems. Scott Page's excellent work[1] highlights the business case for diversity—if you search the internet on this topic, there are more than 35 million results, including articles from business-oriented papers or journals linking increased diversity to innovation and productivity. In addition to issues of equity or fairness, diversifying our profession is an imperative that we need to follow in order to achieve our mission/vision.

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1 Page SE. *The Difference: How the Power of Diversity Creates Better Groups, Firms, Schools, and Societies.* Princeton, NJ: Princeton University Press; 2007.