EDITORIAL

Professional Liability and Litigation

The Thin Edge of the Wedge?

With the ever increasing trend towards consumerism and the accompanying demands for greater privileges and rights for the consumer, there has been an increasing number of lawsuits against all types of health care practitioners. Underwriters, quite naturally, are seriously concerned with this trend, especially in light of all too frequent extraordinary awards favouring the plaintiffs.

One immediate result has been a tripling of premiums for professional liability insurance for some physicians in several states in the US. Certainly other health care practitioners have been affected, but it is physicians who have been hardest hit. Even the nursing profession is giving this aspect of management deeper consideration. To date, Optometry has had a minimal number of lawsuits.

The number of legal actions against Canadian practitioners, meanwhile, is growing, albeit not as fast as in the United States and all professions, as a result, are having to review their attitudes on this matter. Optometrists are at risk in two areas particularly: failure to recognize and refer pathological conditions and failure to counsel patients properly as to the limitations of the lenses and frames of safety eyewear.

Statistics show particularly that eye injuries arising from the shattering of safety lenses and breakage of frames are increasingly the subject of lawsuits. The actual charges vary, depending on the nature of the injury and the judgement of the plaintiff's counsel as to the winnable aspects of a particular case.

The following two cases reveal the different approaches taken in two suits, one of which was successful and the other lost by the plaintiff.

In one, a plaintiff obtained a pair of industrial safety glasses which were shattered as a result of an accident in a squash game. The plaintiff won his suit on the basis that the practitioner had not informed the plaintiff that carbonate lenses in a more appropriate frame would have provided better protection.

In the second case, the patient obtained a pair of dress safety lenses which he felt would provide adequate overall protection. However, he happened to walk directly in front of a golfer who was driving off from a tee. The ball struck the glasses, shattering them and causing a severe trauma, including a cataract. The glasses at that time were two years old and had been dispensed by a practitioner who had since retired and, in fact, was no longer living in the patient's city. The plaintiff, unable to sue the dispenser, brought suit against the laboratory which had fabricated the glasses. This case, however, was dismissed on the grounds that the patient had not acted prudently by stepping out in front of a golfer as he teed off. The laboratory, in its turn, was able to satisfy the court that their certificates of impact resistance warn wearers that safety eyewear is not unbreakable, demands some care and that, further, normal wear and tear can reduce the impact resistance capability of such lenses.

What then is the moral to this story?

Actually, there are several.

All practitioners should carry adequate liability insurance. Prescribers and dispensers alike need to keep proper records as to the type of safety lenses and frames supplied, who fabricates them and what the accompanying certification actually says.

Practitioners should explain the types of safety lenses available and the limitations of certain frames, depending on the intended use of the glasses. In this respect, one may have to prepare a written handout to cover fully these explanations.

For example, **Group 1:** Ordinary hardened crown glass with thickness that varies with the power and size of the lenses; ordinary CR-39 plastic, which is better than glass with thickness that varies with the power and size of the lenses.

Group 2: Dress safety: either crown glass of thickness at least 2.2mm, tempered by chemical or thermal methods; CR-39 plastic of appropriate thickness.

Group 3: Industrial safety lenses. Industrial safety frames are a prerequisite; crown glass of a thickness at least 3.0mm, tempered by thermal or chemical means; CR-39 plastic of appropriate thickness.

Group 4: Theoretically the best protection possible, but still breakable. Dress thickness polycarbonate lenses; industrial thickness.

The selection of the frame, particularly for sports use, presents a problem. Eye wire rims larger than the diameter of a squash ball are not recommended for this sport. If the ball were to dislodge the lens, it should not then be able to pass through the frame rim. In industry, the safety supervisor or the consulting safety specialist will indicate the need for side shields. Depending on the type of work, a lens size may also be indicated that will assure the maximum protection.

A handout, based on the foregoing discussion, would be one way to inform our patients. Another would be to enlarge a copy and display it in the dispensing area of the office.

The very least a practitioner should do is record all aspects of the glasses and the patient's comments with respect to intended use.

GMB

Musings on Aniseikonia and Monocular Ocular Implants

Monocular cataract extraction followed by lens implantation is a surgical procedure which is becoming more sophisticated, more successful and less risky, which

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accounts for its increasing popularity among physicians and patients, not to mention some optometrists.

The main advantages appear to be the potential restoration of binocular vision and the elimination of bulky spectacles or the difficulty that some patients have with contact lenses. Of course, as most of these patients are elderly, some type of over-correction is essential to permit reading or other near point tasks, unless a monovision technique is applied.

There is one aspect of monocular ocular lens implantation which may not have been given the attention it deserves, but which optometrists are best equipped to understand and to manage. We are referring to the induced aniseikonia and induced vertical prismatic effects resulting from this modern surgical procedure.

The study of aniseikonia has been taught in undergraduate courses since the early forties, which is not even to mention its presence on many lecture programmes and continuing education courses up to the early seventies. Most optometrists and optometry students tend to consider the study of aniseikonia as a mere theoretical concept and not as a clinical entity. As a result, they neglect the subject once they have passed their licensing examinations. Fortunately, this attitude is changing, particularly for present day students who are exposed to the more recent developments in the aniseikonia clinics at our schools of optometry. Aniseikonia is now becoming a real clinical entity as the number of monocular ocular implants increases in our aging population.

In cases of monocular cataract surgery followed by ocular lens implantation or the use of an aphakic contact lens (in which the fellow eye is normal and unlikely to require surgery for months or years, if at all), the presence of aniseikonia cannot be ignored. Optometrists, upon return of the patient after surgery, have a responsibility to test for its presence and to counsel the patient and correct the condition if symptoms such as discomfort or space distortion are produced.

From our studies in physiological optics, we have learned that a change of 1mm in axial can induce up to 3 diopters of refractive change. We know that the nodal points of the eye are nominally 7mm posterior to the cornea and that their position will be varied if there are changes in the values of the optical components of the eye; anterior chamber depth, crystalline lens power and thickness of the lens and axial length. Changes in the indices of the aqueous and vitreous may not be significant but do have some influence, at least theoretically. In addition, the position of the pupil and the principal planes also affect the retinal image size.

What effects on total refractive power of an eye and magnification of the retinal image will result in an anterior or posterior implant is used? Implants are much thinner than the crystalline lens. Is such a variation a significant factor on refraction and magnification? Does corneal curvature and its sag value to the angle where the clips on an anterior chamber implant come to rest affect the results significantly by inducing variations in the new chamber depth? Does corneal curvature change enough due to the surgery to influence the overall outcome?

Biometry using an ultrasound device has come of age. This will no doubt facilitate the choice of the power of the implant and indicate its best location if the overall optical properties of the eye are to remain unchanged from the pre-operative state. But is such an outcome possible since the implant cannot be located in the same position as the crystalline lens? Can the design of implants be further refined to accomplish this or changes be made to the material's index and still remain non-toxic?

There remains a basic and fundamental question. Should the ultimate result be directed to achieving ametropia or to a refractive state approximating the pre-cataract refractive status?

True, this discussion becomes academic if the fellow eye must undergo surgery in a relatively short time. However, there are sufficient numbers of monocular ocular implant cases in existence to reactivate an interest in aniseikonia and its clinical applications. *GMB*