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Practical hints to help avoid professional liability

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Practical hints to help avoid professional liability

Abstract
A professional liability claim need not portend an inevitable disaster resulting in an unfavorable verdict, the loss of a professional reputation and payment of a huge monetary judgment. Proper recordkeeping, upholding the standards of the “prudent practitioner” and general common sense can make a long stride toward a successful defense. Incorporation of these elements in your everyday practice, long before a claim is ever made, can help provide the most defensible position should a claim, in fact, be made. This paper attempts to give the reader some general ideas and practice hints to help avoid malpractice situations in the first place or at least make them more defensible if litigation ensues. However, it does not purport to discuss every aspect of optometric practice that can result in a claim, to have reviewed every case on the subject or present a final definitive statement or law in any given jurisdiction. On the other hand, the paper does hope to help the reader understand the general legal theories that are applicable, the major areas for potential claims, along with a presentation of illustrative cases, and provide the reader with some suggestions to help avoid or minimize any potential litigation.

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PRACTICAL HINTS TO HELP AVOID PROFESSIONAL LIABILITY

By
Jana M. Bauer

A Thesis Presented to the Faculty of Pacific University in Partial Fulfillment of the Requirement for the Degree Doctor of Optometry

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ABSTRACT

A professional liability claim need not portend an inevitable disaster resulting in an unfavorable verdict, the loss of a professional reputation and payment of a huge monetary judgment. Proper recordkeeping, upholding the standards of the "prudent practitioner" and general common sense can make a long stride toward a successful defense. Incorporation of these elements in your everyday practice, long before a claim is ever made, can help provide the most defensible position should a claim, in fact, be made. This paper attempts to give the reader some general ideas and practice hints to help avoid malpractice situations in the first place or at least make them more defensible if litigation ensues. However, it does not purport to discuss every aspect of optometric practice that can result in a claim, to have reviewed every case on the subject or present a final definitive statement or law in any given jurisdiction. On the other hand, the paper does hope to help the reader understand the general legal theories that are applicable, the major areas for potential claims, along with a presentation of illustrative cases, and provide the reader with some suggestions to help avoid or minimize any potential litigation.
Introduction

Malpractice -- the very word brings forth to mind a nasty courtroom battle, sleepless nights, the loss of a professional reputation or perhaps even shame and guilt. In short, it evokes the vision of a living nightmare. On the other hand, there are those who feel that it cannot happen to them; only the "bad" doctors have to deal with this. Well, let's face it. Realistically, any optometrist no matter how competent can find himself named in a malpractice claim; however, that is no reason to despair. If a practitioner has conscientiously maintained proper documentation, exercised due caution and upheld the standards of the "prudent practitioner" in the provision of professional eye care, then he has already made a substantial step towards a successful defense. Of course, in the event of an actual act of "malpractice" the optometrist will be held liable, but the judgment can be held to a minimum. In order to build a good defense, the process starts long before a claim is ever even made. It is incorporated into the day-to-day practices in an optometric office. This will in no way totally eliminate the stress incurred should one be named in a claim; however, it should help relieve the panic, despair and the temptation to alter records which could destroy a defense. With the knowledge of having taken all the proper precautions in order to provide the most defensible position before the claim was even made, the optometrist will be in a better frame of mind and better able to assist his insurance company and lawyer to develop the most advantageous defense possible, given the circumstances of the particular case.

Scope and Purpose

The approach of this paper is primarily a literature review, along with an examination of some of the more relevant cases. This paper does not purport to review all the cases on the subject nor does it purport to present a final definitive statement or law in any particular jurisdiction. It is hoped that it will give the optometrist some general ideas and practice hints to help avoid malpractice claims or at least make them more defensible if he is unfortunate enough to have a claim or suit brought against him. An attempt is made to examine areas that frequently cause claims, as well as others which have a greater potential for claims and suits such as contact lenses
and pharmaceutical agents. Non-technical areas which have caused malpractice suits like abandonments of patients during a continuing course of treatment, failure to refer in a timely manner and liability for the acts of employees, technicians and other professionals will also be explored.

Malpractice is a subject that evokes a great deal of subjectivity and emotionalism, as well as, unfortunately, a certain amount of what can only be called ignorance arising from the lack of proper perspective. Some articles in optometric and medical journals have been written with the assumption that whatever happened to that particular practitioner is the only thing likely to happen to anyone with a similar claim or suit. This has prompted literature such as "How I Won My Malpractice Case"; the optometrist lives through the nightmare, but is not in control of the defense of the case. The outcome is primarily a product of the work by the investigators, lawyers and insurance companies.

Other articles indicate that malpractice simply cannot be a problem for optometrists because the area of risk is much narrower than the general practice of medicine. One article took the position that since the oldest jurisdiction permitting use of therapeutic drugs by optometrists had only two or three tried cases in the eight years since the law was passed, this area of practice is not a problem for malpractice. This is fallacious because it fails to take into consideration the following normal delays. Most large plaintiff's personal injury firms who file malpractice suits against professionals do not actually file a lawsuit until just before the statute of limitations has run, usually two or three years after the occurrence is known to the patient. In many jurisdictions, the statute of limitations does not begin to run until the patient realizes he is injured, instead of the day the act took place (although there are exceptions). After the filing of the suit there are delays that can range from one to five years before trial depending on how crowded the local courts are. In addition, only 10% of the suits filed are actually tried. After the case is tried, the decision, although readily available for public inspection at the courthouse, is not published in the law libraries and thus considered in legal literature and briefs for other cases. Only appellate decisions are published in the law books. Some insurance companies do circulate
copies of part of the cases that they feel are unusual to their own employees, but on the whole, the "law books" represent the appeals from those cases. Furthermore, very few of the cases are appealed, as it is an expensive process. Insurance companies usually pay the judgment if it is not a totally outrageous amount. The appeal process itself takes another one to two years.

Add to these factors the fact that of all medical malpractice cases filed, typically two-thirds are won by the defendant doctor and the result is that if you add up the time delays and the percentage of cases that are likely to show up in appellate court reports in a law library, one can soon see that there are perhaps only two or three percent of filed suits that will ever appear in the law books. Additionally, these will only appear five to nine years after the injury has been discovered which may be some time after the act of malpractice actually occurred. Therefore, articles taking solace in the fact that TPAs have been in effect for eight years in a small population state and from the fact that there have been only three reported lawsuits, simply do not have a valid sample from which to draw the conclusion. It will take time to determine the effect that therapeutic drugs have on the number and type of claims filed.

The contribution the optometrist can make to reducing his own malpractice problem, and the problems of the profession in general, fall into two or three areas. Optometrists should make sure that they adhere to the standards of treatment, especially in the area of therapeutic drugs. They can avoid another classic mistake made by the medical profession in the early days such as cover-ups and altering records, which is always fatal when it comes out in the courtroom. As a wise judge once said, "fraud vitiates all". If you are caught in a lie during a trial, you are almost in a situation where you might as well hand the other party a blank check.

Malpractice is a matter of state law and will differ from state to state in the details. As was stated earlier, it is not the purpose of this paper to define the law in any particular jurisdiction, nor is it to write a detailed legal book or define the bottom line of the case law in a particular jurisdiction. The reader should resist the temptation to use this paper to "solve" a particular pending claim or case. Nevertheless, it is essential that the optometrist do a little "thinking like a lawyer" in understanding the basis of the legal system in order to be better prepared should he be
Different Types of Legal Theories That Can Result In a Malpractice Judgment Against an Optometrist

As is true in the general field of medical malpractice, the fact that a procedure is not successful or that it leads to horrible results such as death or blindness, does not in and of itself impose liability on the professional attempting the procedure. The question is whether the professional carried out the treatment in a non-negligent, professionally competent manner within the standards imposed by the law on professionals of all types. It is also important to note that the legal standards are somewhat like the Bible. They are a little vague so that they remain flexible, and they are dependent upon the facts of each particular case. Nevertheless, they are standards, although they are not black and white.

It should also be remembered that the standards of legal liability are set by the legal system and the constitutional principles applied through the judicial system. No profession or any other group of people is allowed to get together and decide itself what its own legal standards will be. The standard is negligence (plus some others which will be discussed later). Negligence is basically a matter of the "due care" a reasonable person, qualified in the profession, would exercise under the circumstances. However, in order for you to be negligent, it must be foreseeable that an injury to someone could occur, if you did not act reasonably and exercise the due care required by the circumstances.

These points become particularly evident in a case like *Helling v. Carey* 83 W.2d 514, 519 P2d 981 (Su. Ct. Wash., 1974). The injured plaintiff first saw the defendant ophthalmologists, who were partners, in 1959, when she was 22 years old and the diagnosis was myopia. There were a total of 11 visits between October of 1959 and October of 1968. At that time, the plaintiff, then 32 years old, was diagnosed as having primary open angle glaucoma. She had essentially lost her peripheral vision and her central vision was reduced to approximately five degrees vertical by ten degrees horizontal. Her IOP had never been tested during all this time.

At trial, the defendant ophthalmologists attempted to defend on the basis that the standard of practice under which ophthalmologists operated at the time was that patients under 40 need not
have their IOP checked because the incidence of glaucoma below that age was one in 25,000, whereas it was 2-3 percent of the population above that age. This was virtually the only issue when the case was appealed before the Washington Supreme Court.

The specific issue as stated by the Supreme Court of Washington was:

The issue is whether the defendant's compliance was the standard of the profession of ophthalmology, which does not require the giving of routine pressure tests to persons under 40 years of age, should insulate them from liability under the facts of this case, where the plaintiff had lost a substantial amount of vision due to the failure of the defendants to timely give the pressure test to the plaintiff.

Several doctors testified that this was in fact the standard for ophthalmologists at the time. The Supreme Court of Washington stated, however:

The one person, the plaintiff in this instance, is entitled to the same protection as afforded to persons over 40, essential for the timely detection of the evidence of glaucoma where it can be arrested to avoid the grave and devastating result of this disease. It's a simple pressure test, relatively inexpensive. There's no judgment factor involved, and there's no doubt that by giving the test that the evidence of glaucoma can be detected.

The Court relied on the 1903 United States Supreme Court case of Texas & Pac. Ry, v. Behymer 189 U.S. 468, at 470, 23 S. Ct. 622, at 623 (1903), where that court stated:

What usually is done may be evidence of what ought to be done, but what ought to be done is fixed by a standard of reasonable prudence (negligence in professional care) whether it usually is complied with or not.

The court also relied on the case of T.J. Hooper 60 F.2d 737, at 740 (U.S. Circuit of Appeals -- 2nd Circuit, 1932):

... a whole calling may be unduly lagged in the adoption of new and available devices. It never may set its own tests.... Courts must in the end say what is required; there are precautions so imperative that even their universal disregard will not excuse their omission.

The Washington Supreme Court in the Helring case held:

Under the facts of this case, reasonable prudence required the timely giving of the pressure test to this plaintiff. ..., it is the duty of the courts to say what is required to protect patients under 40 from the damaging results of glaucoma.

This case is widely cited in non-legal literature as being the first time in which a court has imposed a specific practice standard. The real point is that the profession cannot by its own actions decide, in effect, to write off a certain group of potential patients (in this case, glaucoma patients
under the age of 40) and do it without any potential liability. The legal standard of care applies to examination and care of all patients, even though, it is a relatively weak standard.

In the *Helling* case a large factor was the ease of giving the test and the fact that no great professional acumen was required in order to interpret the results. As for it being the first case imposing a professional standard of practice, that is not true either. The case of *Shives v. Chamberlain* 168 Or 676 126 Pac. 2nd 28, involved similar facts where a patient over 50 was suffering from glaucoma. Testimony as to the professional practice standard in court stated that the approved method at that time of testing eyes to determine whether glaucoma is present was by use of a tonometer, and the defendant made no such test.

As in the *Helling* case, there had been an extended period during which the symptoms of glaucoma in the form of blurring and impaired vision had been apparent, and the plaintiff's eyesight was growing steadily worse. There were repeated visits for 14 months to the defendant. Six months after the last visit to the defendant, the plaintiff consulted a second ophthalmologist, who diagnosed his condition as glaucoma and was able to arrest the progress of the deteriorating condition. The Oregon Supreme Court affirmed the judgment in favor of the plaintiff.

The lesson to be learned from all this is twofold. Do not ignore past history or one may be doomed to repeat prior mistakes at great expense and the best defense is high quality practice, reasonableness, and common sense with respect to the patient's rights. Note the emphasis that the Washington Supreme Court placed in the *Helling* case on the simplicity of the test, the lack of unusual expertise required to interpret its results, and its low cost. With respect to malpractice, one can learn from the mistakes made by the physicians over the last 25 years rather than go ahead and make all the mistakes again.

Let's now examine the legal standards of care and theories which can result in a malpractice judgment being imposed upon an optometrist. The normal negligence rule concerns "that degree of care that an ordinary man would use under substantially the same or similar circumstances" (i.e., reasonableness) and in fact, these standards apply to every member of society. The basic concept is that of fault and the fact that there is no liability without fault. Fault arises from an intentional
or negligent act which causes an injury, with a few exceptions like agency liability.

**Agency Liability** -- In general, that which a person can legally do himself, he can legally do through another, called an agent, except that he cannot "lend" a professional license to another unlicensed person to permit him to practice the profession. An agent is essentially an employee, or a partner or someone whom one authorizes to do something in one's place who is not a true, independent contractor as defined by law. Insofar as optometrists are concerned, the courts can impose liability on the person, known as a principal (the optometrist), who employs an agent in several potential areas. There can be an agency relationship between the optometrist and other professionals such as another optometrist, a partner, an optician or technician. In the agency situation, a principal or employer is liable for any mistakes which constitute malpractice or negligence made by his employee or agent, even though the principal himself has done nothing wrong. He may also be directly liable for his negligence in hiring an incompetent agent, failing to supervise adequately, or knowingly permitting non-professional agents to carry out professional activities. Agency liability concerning non-professionals and employees refers to people outside the profession, such as the receptionist. Serious legal problems can arise when these non-professional individuals are improperly delegated professional functions. A common situation is the receptionist who, with or without the knowledge of her optometrist employer, gives professional advice to patients or tells patients that she is sure they do not have an emergency and can wait until the optometrist comes back from vacation instead of being referred to another optometrist or ophthalmologist.

In many jurisdictions, the professional duties themselves are regarded as "non-delegatable duties," which, if they are in fact delegated to a non-professional, automatically makes the optometrist liable for the consequences. The employee will also be liable for the same injury, but that does not make the employer optometrist any less liable. Furthermore, since the person who wins a lawsuit against two defendants can collect from whomever he pleases (not 50-50, but in whatever portions he desires), he will usually collect from the person who is more able to pay the judgment--namely the optometrist.
If there is actual or apparent authority on the part of the employee or agent, even in a situation where he is not actually authorized, this will impose liability on the optometrist. Apparent authority arises from, in effect, clothing the person with the trappings of being a professional. The trappings may be nothing but the professional office itself. If the subject matter of the negligent act or omission is within the scope of the profession, then there may be "apparent authority." However, if the activity of the agent is so far beyond the scope of what could be apparent authority, then the employer or principal will not be liable.

The great legal trap which the medical profession has fallen into in the past was that if you have something which is clearly beyond the apparent authority of the receptionist, but not so far beyond the subject matter of the treatment given in the office, and in fact that advice, recommendation, or other act of negligence is given without review by the doctor or optometrist, it will become authorized if subsequently the optometrist or the physician engages in a cover-up. In one of these situations, candor and prompt action by the professional to rectify the situation is the only solution. It will at least hold down the size of the claim. The agency situation, then, is one of liability without personal fault on behalf of the professional, if sued. When you authorize someone to do something for you, you in effect make their mistakes, yours.

Product Liability -- Other exceptions to the "no liability without fault" principle arise in the product liability field where there is warranty liability. Such product liability or warranty liability is usually limited to defective products. Thus, the fact that a product is "defective" is sufficient to impose liability. The injured patient does not have to also prove the defect was caused by someone's negligence. Therefore, this product liability is sometimes called "strict liability." The "strict liability" for defective products may be applicable to the optometrist when he is dispensing glasses and other products. A very minor and rare exception is the so-called warranty of workmanlike conduct, which has practically never been seen in malpractice cases. Therefore, one can probably safely conclude that the primary area of liability for an optometrist, when it comes to services, as distinguished from products is negligence or professional liability (the normal malpractice standards).
**Strict Liability** -- "Strict liability" without reference to "defective products" is the third exception to the no liability without fault principle. It relates to certain extremely hazardous activities such as the keeping of explosives, building a dam to hold water, etc. It is almost never applicable to malpractice, although Judge Utter of the Washington Supreme Court in the *Helling* case suggested that that was what the court was really doing in that case.

**Professional Liability** -- Liability with proven fault includes, of course, liability for professional services. The professional standard of care includes the normal elements of negligence with one modification. In general, negligence requires that the defendant failed to exercise ordinary care (namely, that "due care" which a reasonable person would exercise under the same or similar circumstances), that the failure to do so was the proximate cause of the plaintiff's injury, and that the injury caused damages. There are occasions where negligence exists, but no one is really injured. In the case of professional liability, the first element is modified to use one of two common rules. The first is the so-called community standard of care and is in reality a weak standard. The second is the so-called "prudent physician" standard and it is not limited to the local community. It has been adopted in Washington in the last several Supreme Court cases, and it is the trend in many other states. For example, a statement of the standard based on the so-called community or locality rule by the California Appellate Court was as follows:

> [A physician has the] duty to possess that degree of learning and skill ordinarily possessed by physicians and surgeons of good standing, practicing in the same or similar locality and under similar circumstances.

> It is his further duty to use the care ordinarily exercised in like cases by reputable members of the profession, practicing in the same or similar locality, under similar circumstances, and to use reasonable diligence and his best judgment in the exercise of his skill and the application of his learning in an effort to accomplish the purpose for which he was employed.


This rule is the majority rule and has been for many years. However, in some jurisdictions, instead of switching to a more definitive and practical standard such as the Washington rule (or the so-called prudent physician rule) which applies statewide, the courts have retained the old rule but expanded the definition of the community or locality to include at least the whole state and
occasionally the entire nation. For example, in the West Virginia case of *Hundley v. Martinez*, 158 S.E.2d 159 (W. Va., 1967), the community rule was established in West Virginia by the testimony of a New York ophthalmologist as to what was good practice during cataract surgery. The details of what constitutes the practice standard within these duties of care for the exact test or procedure at issue in the case, is always presented by the expert testimony of somebody within the profession during the case. Thus, it is not dependent on things such as written practice standards, although they are evidence leading to what the local standard is, as in the *Helling* case.

One trap to watch out for is that some courts, again instead of shifting like Washington has to the prudent physician standard, have no longer confined the definition of the practice standard to the opinion of someone in the same profession. For example, pathologists have been allowed to testify as to what is good surgical practice when they have actually had experience observing operations and testing tissue afterwards in cases involving surgeons. 4

The State of Washington in three recent Supreme Court cases has adopted a new standard, that of the so-called "prudent physician". The standard is the failure to exercise that degree of care that would be exercised by a "prudent physician" anywhere in the State of Washington and it is not limited to the local community. Since the "prudent man" standard is the standard for negligence for anything other than professional liability, the prudent physician standard is practically the same thing. It also avoids many of the traps and problems that arose under the old community rule.

Let's look at it realistically. In some remote communities which are unattractive to live in and which have a difficult time attracting doctors, the community standard of care can be rather poor simply because no one with experience might ever stay for more than a year or two. A second bizarre problem is a community with only one doctor in the particular specialty. Who do you compare his practice to in order to determine whether or not he was negligent? These situations have helped to shift the standard away from the old community rule.

**Warranty Liability** -- As noted above, this is another legal theory under which one may be liable for a portion of one's practice. With only one small exception, which is rarely used, warranty liability arises from and only from the sale of a product. 3 This, of course, can affect
the optometrist if he engages in the direct sale of glasses, frames, contact lenses, solutions, etc. One should assume that if one sells products as a part of one's practice, one may be subject to warranty liability, because as negligence applies to all activities of an individual that might result in injury or damage, so also does warranty liability apply to the sale of virtually any product. It is virtually never applied to the sale of services, although in some jurisdictions a case-law-developed or common law "breach of warranty of workmanlike services" has occasionally been imposed. I have not seen this in medical malpractice cases or in a case involving an optometrist. However, this paper does not purport to have researched every last case.

Breach of warranty simply means allowing a defective product to reach the marketplace. The manufacturer, the wholesaler and the retailer are equally liable. It does not matter how careful the parties were in trying to prevent a defective product from reaching the marketplace. If, in fact, the defective product did reach the marketplace and as a result someone was injured, then there is liability. The exact types of defects which violate specific warranties, imposed by law, is beyond the scope of this paper. In the case of an optometrist dispensing glasses in his own office instead of simply providing prescriptions the patient fills elsewhere, he is exposing himself to some degree of warranty liability. This type of liability was first developed from case law to protect the innocent purchaser from hidden defects in products that he purchased. With respect to the matter of dispensing products, the professional standard of care is irrelevant. The care used by the optometrist, if the defective product actually reached the patient, is also irrelevant. There is only one major defense in a warranty case and that is misuse of the product itself, or simply establishing that the product is not defective.

There are several types of warranties in different jurisdictions, but basically the common ones include "merchantability" (whether the product is generally salable or not) and "fitness-for-purpose warranty" (which is relevant in a situation where the wrong product is sold to the customer). The Uniform Commercial Code statutes added the so-called "descriptive warranty" wherein any representation, description or appearance from a sample shown prior to purchase of the product by the patient provides a guarantee that the product will meet those
specifications, description or sample when he receives his ultimate product. Failure to meet those exact descriptions or representations or to be substantially the same as the sample will lead to breach of warranty liability. A particular product sold with an optometric service could potentially be deemed as a product subject to the warranty laws.

A brief comment needs to be made with respect to the joint liability of the retailer, wholesaler and manufacturer. The optometrist is, in effect, the retailer if he dispenses the product; if he does not dispense the product, but simply furnishes a prescription, there probably is no warranty liability except in the rare exception of the states that impose a warranty of workmanlike services. The injured party can sue any or all of those three defendants; and once one is sued, assuming that the proper procedural maneuvers are made within the right timetables of the local court rules, the other two can be brought in. For example, if a claim was made based upon the dispensing of a defective pair of frames (sold for industrial or sport purposes and did not meet federal standards) and only the optometrist is sued, the manufacturer can be brought in if the case involved an inherent defect in the product.

Large responsible manufacturers generally are well prepared to defend these types of cases, and do so in order to protect the salability of their products. They generally take over the defense on behalf of all parties, so the optometrist, though he may have been the first and only defendant, may find himself to be almost a sideline witness in the case, if for example, a major ophthalmic manufacturer becomes the defendant and the allegation is that their product has an inherent defect which, when given to a patient, breaches the warranty (since it is a defective product).

It should be remembered that because one of the parties subjected to joint liability is liable, does not automatically prevent the others from being sued. Anyone can be sued for anything, and then has to undertake the burden of going into court and trying to defeat the lawsuit, either by dismissal through motions to dismiss or summary judgment, or actual trial of the case. If a case is concluded in favor of an injured party, and that party receives a verdict and judgment against more than one defendant, the law does not stipulate from whom the injured party, who now holds a judgment, can satisfy his judgment. In short, he can get all from one party, jointly from two or
more parties, or however he pleases.

Naturally, in a warranty case if the manufacturer is held liable, along with the retailer and the wholesaler, most successful plaintiffs will collect the judgment from the manufacturer, especially if it is a large sum. They know the company has enough money to satisfy it, frequently has insurance and it does not involve potentially having to liquidate property at greatly reduced prices in order to satisfy the judgment, which can be a self-defeating process and run further legal fees. The latter could happen if a plaintiff went after an optometrist who has little or no assets (just started in practice or something of that nature) and for some unknown reason ignores his option of simply collecting from the manufacturer who put out a defective product. Many people think that if they are held liable with another party in a malpractice case that the successful plaintiff is restricted to getting 50 percent from each party, but generally, this is simply not true, absent special statutes, limited to a few specific types of cases in some states.

A good practice hint for an optometrist who dispenses optical materials, when the materials themselves injure a person and it is claimed that there is an inherent defect in the materials (not necessarily a situation where the only injury was caused by a modification made by the optometrist), is that he would be well advised to get his own lawyer, aside and apart from the insurance company lawyers (especially if the claim is large), and immediately consider putting the manufacturer on notice that he intends to bring them into any potential lawsuit. In most instances, with a responsible manufacturer, this will provide free legal services and expert witnesses that the individual could not afford in order to defend the case. In some cases it may produce a successful "tender of defense", which is a situation wherein the defendants agree among themselves that the party who was first sued is not liable and therefore one of the other parties completely takes over all of the liability of the person (the optometrist in this instance) who was initially sued. 3

In a bad case (one with very serious permanent injuries) or in a case where there is a risk that the recovery could exceed insurance limits, do not rely solely on the attorneys provided by the insurance company. This is especially true in a bad case at the very beginning because some of these maneuvers have to be made long before a trial begins. This does not mean that all of the legal
work is duplicated all the way through. Have a competent trial attorney review your situation initially and advise you as to what should be done.

**Insurance** -- One aside at this point is necessary and that pertains to the subject of insurance. This paper does not involve an exhaustive analysis of professional "errors and omissions insurance" and the conflicts of interest that can develop between the optometrist and the insurance company after an injury has occurred. A situation can occur where the case is clearly one of liability and there is really no defense whatsoever, but the insurance company may want to go to trial because the last settlement demanded by the injured party is so high that they view it as outrageous, even though it is well within the policy limits. In this instance, the policy rarely is worded in such a manner as to allow the optometrist to insist on a settlement and a very high payout in order to avoid the bad publicity of a prolonged trial. At the other extreme, a conflict of interest between the optometrist and his insurance company can also arise in a situation where the claim is fairly small (the injured party has offered to settle for a few thousand dollars), but there is no real ground for liability. Insurance companies are notorious for settling these kinds of cases. 5

The problem is especially evident when it involves a case that could easily have been won and the insurance company is solely trying to avoid $10,000 or $15,000 of attorney's fees on a case that they can settle for $5000. This can, of course, result in damage to the reputation of a perfectly innocent optometrist.

In general, insurance companies do have the right to settle over the objections of the insured, since it is their money that is involved. There is some trend towards better insurance policies and in a few instances where a professional medical society has formed its own insurance company only to insure its members, the problems are greatly diminished. 4

The other major danger area with respect to insurance for professional liability is the situation where the case has a potential for exceeding the limits of the policy. In a lawsuit, the injured party has his "day in court" or trial only once (which of course is not literally one day) and he must recover, on that occasion, for all the damages caused by the injury including future medical costs, lost wages, any special care that is required because of the injury, etc. 3 He cannot
come back after a judgment has been entered and get a second trial because there were further medical costs. If those numbers added together, plus some allowance for pain and suffering allowed in the particular jurisdiction, come anywhere near the policy limits, the optometrist should hire his own lawyer immediately, because his interest and that of the insurance company will soon diverge with disastrous results. An old rule of thumb that has been used by some defense lawyers (which may or may not work in a particular case) is to add all of the so-called damages listed above and multiply by three. If the number is close to the policy limits, then it is highly advisable to obtain your own defense, in addition to the insurance company's. This will cost additional money, of course, but otherwise things can happen during the trial of the case that will cause a huge burden to fall on you which the insurance company will not resist very much because their liability is limited and yours is unlimited.

In summary, some specific areas which have imposed liability for defective products or warranty liability upon ophthalmologists and optometrists include: failure to use appropriate materials (like frames) for a person who in the case history informed the doctor that he participates in high-risk sports such as racquetball and tennis which do not actually meet the applicable ANSI standards even though they may be advertised as "sporty" or appropriate for sports; failure to inspect materials actually dispensed; and, of course, failure to actually dispense safety glasses in compliance with ANSI standards. In these cases, be sure to recall what was said about the trap of the descriptive warranty under the Uniform Commercial Code. "Sports glasses" and "safety glasses" must meet the ANSI standards or they are defective if they are used in these areas.

Battery Liability -- Another possible area for liability involves "battery" which is defined as any non-consensual contact with a person's body or any extensions thereof, such as clothing or even an automobile, with the exception of ordinarily accepted contacts in society. One cannot sue someone for battery on a crowded sidewalk because their coat brushed yours. This form of liability is relevant in the context of this paper in that any non-consensual procedure involves battery liability, as does the use of drugs.
A doctrine of informed consent in medical situations defines when the battery becomes consensual and therefore no longer a battery. Basically, in any procedure or drug situation it is essential that the patient be fully informed of all of the common risks, complications and possible side effects that he may be exposed to in language that he can easily understand (not technical jargon). In addition to disclosing the risks, the patient should also be given some idea of the probability for their occurrence and be made aware of any individual characteristics that may increase the risks to that patient. This is one of the major areas where optometrists can avoid massive problems if they do not make the mistakes that medical doctors have made in the past. Even today true informed consent, in an understandable and realistic manner so that the patient can make a conscious decision with full knowledge of the facts, is still seldom accomplished in a medical situation. Frequently there is little or no disclosure of the side effects of medications or definition of the scope of the particular side effect problems for the particular patient in light of his medical condition. In the states with therapeutic drug laws this is a very important point. Optometrists need to be careful and make sure that informed consent is provided concerning TPA drugs, as well as diagnostic drugs. The medical profession has definitely made mistakes in this area of informed consent and has had liability imposed in situations where there was really no problem with the competency of the procedures otherwise. Let's not make the same mistakes.

Some professional articles and lectures with respect to the doctrine of informed consent have stated that informed consent need not be given in regard to some procedures (such as contact lens fitting or the type of lens used for a particular patient) as to risks because others in the community do not. Full disclosure and informed consent will have to be given as to any substantial risks. It is already true, regardless of the standard applied, that in the area of drugs there are no exceptions to the informed consent rule. Basically, the safe assumption is that there are no exceptions in any area of practice unless the risk is such that it simply has never occurred or is very insignificant in its consequences.

It should be noted that battery liability is the only area of liability that is both civil and criminal that has been discussed in this paper. In other words, if a battery such as a
non-consensual procedure or drug is used, it is possible in a case of a very severe injury that the
optometrist could go to jail, as well as having to pay monetary damages in a civil suit, although this
is highly unlikely to occur. A drug case with no disclosure of risks whatsoever, where one of the
risk factors was unusually high for the patient because of a known particular condition the patient
had, and that results in total blindness, could be such a bad case, especially if the injured party
were a young person or a professional who could not continue to perform in his profession if he
were no longer sighted. In theory, there may be a reckless disregard for the safety of the patient.

_Breach of Contract Liability_ -- This is yet another area that can concern the optometrist. A
contract is basically any agreement or representation upon which the parties may agree or upon
which the other party may justifiably rely to his detriment. Implied-in-fact contracts arise even
though neither party intends them to be “contracts”. Of course, contracts may be oral as well as
written. In short, any oral representation or promise as to benefits of the treatment, or any end
results of the treatment, impose contract liability on the person making such representations and
may also create a descriptive warranty liability under the Uniform Commercial Code as described
earlier, if products are involved.

In addition to these quasi-contractual representations that cannot be fulfilled, there are
ancillary matters with respect to the practice that can impose breach of contract liability, such as
unauthorized release of patient medical data or records. The optometrist, of course, should be sure
that he has any authorization to release in writing from the patient himself, or in the case of a
minor, his guardian.

These quasi-contractual liabilities also can arise in the reverse context, that is, where the
patient is not suing the optometrist, but he desires to prevent the optometrist from testifying in a
suit that the patient is involved in with a third party with respect to his medical condition. This
occasionally arises when the other party to a lawsuit subpoenas the optometrist or his records in an
effort to use some pre-existing condition in the vision record to show that the visual injury in the
third party accident was not caused by the accident itself.

Commonly these issues will come up in third party cases involving automobile accidents or
workmen's compensation cases. The law is a little muddy on this subject of preventing the optometrist from testifying. Some states purport to claim that an optometrist does not have the same privilege to refuse to testify, or the patient the right to compel him not to testify, as medical doctors. This is a matter that has to be researched currently on the basis of the law in each case, and is a changing situation.

**Ancillary or Third-Party Liability** -- These cases involve situations where property or another person, other than the patient, is injured because of a defective visual product, negligence or malpractice on the part of the optometrist. A clear example would be an optometrist brought into a suit by the driver of a car who was injured when the patient, who attempted to drive with dilated eyes, collided with the other party's car and injured him, and the claim is made that the patient was not properly warned not to drive an automobile in this condition. There are also third-party cases where property damage may be the result of vision defects not properly corrected.

**Statute of Limitations** -- This is the maximum period between the time when one is injured by malpractice or the time one discovers or should have discovered the injury (depending on the type of statute) and the last day you can file suit for that injury. Without a discovery type of statute, if a treating doctor causes injury to an eye on a given day and the state has a two-year statute of limitations, the patient has exactly two years from that day to file suit or forever be barred from filing suit and not be able to recover for the injury. The so-called discovery type of statute of limitations is one which runs not from the act that caused the injury, but instead from the time of discovery of the injury or the time period within which one should have discovered the injury. The reason for this statute of limitations is based on the fact that certain injuries may take years before a diagnosis is made, such as for example, a carcinogenic chemical or drug that does not result in cancer symptoms until 5-10 years later. Obviously, without this type of statute of limitations no one could ever file in these cases; practitioners could be as negligent as they wanted to because the statute of limitations would run before the symptoms would appear.
There are two types of discovery statutes. Some depend on actual discovery, whereas others state that it is based on the time period within which one should have discovered the injury. The latter type starts running when symptoms are apparent to a layman, even though he may not go to a doctor for diagnosis. The former type does not begin to run until the patient is told by a doctor what is wrong with him and has had sufficient information to relate it to the act of malpractice.

In addition, the matter of statute of limitations is complicated by two other factors. In the case of malpractice, some statute of limitations which are not the discovery type presume that when a long course of treatment is involved, the injury occurred during the last visit to the doctor, if that visit involved treatment of any type. This is particularly important in failure to diagnose cases. It also has important aspects for optometrists because many states have held that if the patient comes back for any purpose other than for treatment and there was no legal duty to treat on that visit, then the visit does not count. The statute runs from the previous visits. In many cases involving optometrists or physicians, when the patient returns to have glasses fitted a few weeks after a vision exam and does not complain of pathology, the doctor probably will not be held liable for failure to discover pathology on that visit. On the other hand, during a routine vision exam, you need to find any existing pathology or you may well be found liable for failure to diagnose.

All statutes of limitation, whether or not they involve malpractice, are subject to tolling statutes. A tolling statute defines the period of time in the middle of a regular statute of limitations that does not count and is subtracted for instance, from the two years in the example stated earlier. The list of items that tolls a statute of limitations includes non-residence in the state and the period of time during which the person is a minor. This, however, is not the gospel in every state, but it is typical of many statutes. If a person moves out of the state six months after an injury, lives outside the state for one year and then returns to the same state, he may have three years to file a suit even though the statute of limitations says two years. In states with a minority type of statute of limitations, it may not start to run for a very long time. For example, if a pediatrician causes an injury to a six-year-old child, the statute of limitations is two years and a person is of age at 18 in that state, it would be 14 years before the statute of limitations runs. Due
to the complications and details of various types of statutes and what evidence deems that a condition should have been discovered, it would be wise not to count on a statute of limitations before a lawyer reviews it and the facts pertaining to the particular case you are facing.

**Further Concerns with Case Examples**

*Informed Consent* -- Typically, the doctrine of implied consent is thought of in terms of written consent forms for major surgical procedures. Actually, the doctrine applies to any form of professional health care services, including optometry, and any form of examination, treatment or the significant risks of a prescribed drug or certain procedures. While the patient cannot tell the optometrist how to practice his profession, the patient is the final arbiter of what is to be done to his body. If he insists on omitting items necessary to good optometric practice, the optometrist does have the right to suggest that he continue his treatment with another health care professional, as long as this is done in a proper manner so as not to constitute abandonment of the patient.

The "informed" portion of this legal doctrine means the patient must be given all relevant information sufficient to have a good factual basis upon which to consent or make a health care decision, before he must decide. The relevant information must be explained in layman's terms, and all material risks or further tests must be explained to him. An absence of informed consent can impose malpractice liability, even if all procedures are properly carried out. One simply cannot impose tests, risks, treatment and procedures on a patient without first telling him what one is going to do and the potential risks. The patient must have all the necessary information, and know to what he is consenting. This was illustrated in the case of *Koegan v. Holy Family Hospital* 95 W.2d 306 at 312-321, 622 P.2d 1246 (1980).

Today, the doctrine has expanded beyond consent to tests and procedures. The optometrist has a duty to disclose any abnormality which may indicate risk or danger, as soon the optometrist is aware of it (95 W.2d 306 at 314). If the abnormality is indicative of a systemic problem, the related condition must be explained to the patient in a timely fashion. Timely means as soon as it is discovered. Do not wait until it becomes the "official diagnosis"; just say the matter discovered is one which could indicate the condition "x". In the case of *Wills v. Klingenbeck* 455 S.2d 806 (Su.
Ct. Ala., 1984), which is reviewed elsewhere in this paper in connection with failure to refer to an ophthalmologist, the optometrist noticed papilledema, but did not tell the patient that it could be an indication of a brain tumor, with disastrous results. The immediate disclosure of abnormalities must be made even if the symptoms are "inconclusive". Keegan v. Holy Family Hospital 95 W.2d 306 at 315.

Failure to obtain an informed consent prior to the event, or failure to disclose discovered abnormalities immediately upon discovery is not forgiven by the fact that other professionals do not disclose until a later time or the old excuse that it was not in the patient's best medical interest to disclose a risk. Keegan 95 W.2d 306 at 318. Generally, the disclosure of an abnormality that presents any risk or danger requires the disclosure of the risks of the condition, as well as the risks of any tests, treatment, and alternative tests or treatment. Keegan 95 W.2d 306 at 319.

Timeliness of the disclosure is crucial.

The case of Evers v. Buxbaum 253 F.2d 356 (C.A.D.C., 1958) is illustrative of some of the legal requirements. It also illustrates that the optometrist must never let economic or competitive factors result in the withholding of material facts from the patient which could put him at risk for injury. In that case the plaintiff was "having trouble with his eyes" which he equated to a need for glasses. He went to an optical chain for examination and fitting. Their regular optometrist was on vacation so one of their opticians arranged for an exam by another optometrist. The doctor examined the plaintiff Evers, discovered some "possible pathology", but never told the patient. Instead, he reported this finding to the optician and suggested referral to an ophthalmologist or a local hospital and prescribed glasses. The optician noted the "possible pathology" in the record, but did not tell the patient either. Approximately 120 days later the plaintiff went to a hospital and was diagnosed as having a papilloma of the choroid plexus and a tumor was removed.

The Washington case of Gates v. Jensen 92 W.2d 246, 595 P.2d 919 (1979) involved a similar situation where high IOP was not disclosed to the patient, nor was the risk of glaucoma or the necessity for a dilated fundus exam or fields. The patient was myopic and 54 years old. Her complaints included difficulty in focusing, blurring and gaps in her vision. By the time her
glaucoma was discovered two years later, her vision had diminished from 20/20 corrected to 20/200 corrected. This case also involved misdiagnosis which will be discussed later. Some states have defined, specifically, informed consent duties by statute.

Washington RCW 7.70.050(1)-(4) provides:

(1) The following shall be necessary elements of proof that injury resulted from health care in a civil negligence case or arbitration involving the issue of the alleged breach of the duty to secure an informed consent by a patient or his representatives against a health care provider:

(a) That the health care provider failed to inform the patient of a material fact or facts relating to the treatment;
(b) That the patient consented to the treatment without being aware of or fully informed of such material fact or facts;
(c) That a reasonably prudent patient under similar circumstances would not have consented to the treatment if informed of such material fact or facts;
(d) That the treatment in question proximately caused injury to the patient.

(2) Under the provisions of this section a fact is defined as or considered to be a material fact, if a reasonably prudent person in the position of the patient or his representative would attach significance to it deciding whether or not to submit to the proposed treatment.

(3) Material facts under the provisions of this section which must be established by expert testimony shall be either:

(a) The nature and character of the treatment proposed and administered;
(b) The anticipated results of the treatment proposed and administered;
(c) The recognized possible alternative forms of treatment; or
(d) The recognized serious possible risks, complications, and anticipated benefits involved in the treatment administered and in the recognized possible alternative forms of treatment, including nontreatment.

(4) If a recognized health care emergency exists and the patient is not legally competent to give an informed consent and/or a person legally authorized to consent on behalf of the patient is not readily available, his consent to required treatment will be implied."

Harbeson v. Parke-Davis, Inc. 98 W.2d 460 at 470-471

With respect to use of a drug, the courts have held that informed consent requires that the patient be told of medical risks that are significant and likely. Smith v. Shannon 100 W.2d 26, 666 P.2d 351, (1983).

Fraud and Altered Records -- Unfortunately the body of law pertaining to malpractice claims developed around claims against physicians, largely not involving ophthalmologists, and in the early years it had a checkered history involving many instances where medical records were altered after a malpractice event occurred to either cover-up or falsely create evidence for the defendant. Most of these schemes backfired because in most instances there was an outside person or an outside portion of the transaction that could be subpoenaed to prove that the record entry did
not reflect what actually happened. In addition, in this day and age, nurses and technicians can no longer be intimidated into silence and plaintiff's attorneys sue them too if they think they are lying and may agree to settle with them separately at no cost if they agree to testify about false record entries. It is important to remember that under the law, fraud is both a civil and criminal misdeed which means that if caught, the defendant will not only lose his malpractice suit, but may also go to jail for criminal fraud. Plus, jail time is also meted out for perjury when the false entries are presented in court. 3

By far the most important reason not to be tempted to alter records is the old judge's maxim, "fraud vitiates all". What that means is that if you are caught in one significant lie, the judge and jury can decide that all the other evidence that you have put on is not credible and can be ignored. The practical effect is to virtually give a blank check to the opposing party in the lawsuit. On the other hand, a good set of records reflective of the events that happened can be the most valuable evidence in the defense of a malpractice claim. Even if there is something in the record that is damaging, a good lawyer can deal with the worst fact situation if he knows in advance the details of the negative evidence.

A simple example of how an altered record that is discovered can cost you everything that is won in a case is that of Langager v. Lake Community Hospital 688 F.2d 664 (C.A.9, 1982). The case was tried in the Arizona state courts and the defendant doctors and hospital won. A highly unusual second suit was filed in federal court. Again, the defendant won based on the statute of limitations which in Arizona revolved around a so-called discovery rule which means the statute of limitations time period does not begin to run until the patient discovers his injury or had all the facts to discover the injury. The plaintiff appealed the federal district court decision to the U.S. Court of Appeals. The Court of Appeals judge discovered that the defendant doctors and hospital had altered their records to falsely indicate that they had given the plaintiff knowledge of his injury at a much earlier date than was true. Thus, they had misled the federal district court into believing that the statute of limitations had run, when in fact it had not. Upon discovery of this fraud by the U.S. Court of Appeals, the judge was so furious at the doctors and the hospital that he reversed both the
state and federal judgments in their favor and gave the plaintiff virtually everything that he wanted.

An example of a conspiracy to cover-up an easily corrected act of malpractice is the case of Rudek v. Wright M.D. & Helena Medical Clinic 704 P.2d 621 (Su. Ct. Mont., 1985). In this case the surgeon left a sponge in the patient after the operation. Every employee of the medical center and the doctors involved when this was discovered, referred to it as the missing sponge. The operation in question was a simple hernia operation. The plaintiff was seen 34 times by Dr. Wright in the first 90 days post-op and no cause of the continuing infection in the area of the operation was ever determined. Twenty days post-op an x-ray was taken which was read and supposedly showed nothing. When caught in this lie, both Dr. Wright and a radiologist said that they had misread the same x-ray. Finally, the patient was taken to another hospital, x-rayed and the missing sponge was found in the second x-ray. The so-called sponge was actually a lap mat measuring 30x30 cm equipped with an x-ray tag so it would vividly show up in an x-ray should it ever be lost. Of course, the first x-ray was subpoenaed and to put it mildly, a radiologist with 20/200 visual acuity could have seen it, yet a trained radiologist and the surgeon involved in this case misread this x-ray. However, tragically the patient was 74 years old and even after the mistake was finally discovered, the infection could not be treated successfully and she died 4 1/2 months post-op. Obviously, if there had not been a 90-day cover-up, reopening when there was little infection immediately after surgery could probably have been accomplished with little risk. Montana is a state that is notorious for extremely small judgments. The Montana Superior Court held that the surgeon was the "captain of this ship" and was liable for this entire charade, and awarded the lady's relatives $75,000. It is obvious that in other states the award could have been many times that amount in such an outrageous case.

The case of Emory Univ. v. Houston 185 Ga. App. 289, 364 S.E.2d 70 (C.A. Georgia, 1987) involves a situation where the faculty of the Emory University Medical School formed a partnership to practice medicine for their own profit in the university hospital, an arrangement very similar to the University of Washington Hospital. The chairman of the Ophthalmological Department of the
hospital who was also a faculty member of the medical school operated on a patient's eye and performed the surgery on the wrong eye. Under Georgia law, medical peer review committees of a certain nature cannot have their records subpoenaed at least until they have prepared their report on the surgical procedure being reviewed. Immediately after the operation and in realization of the mistake, the doctor sent all of the records to the peer review committee so the patient could not get them and prove the mistake. The records of pre-op visits to the surgeon where any recommended surgery to one eye (the one not operated on) were altered to indicate that the recommendation was for the other eye. In addition, the surgeon extracted the portion of the records of the operation itself that indicated proper surgical procedures from the peer review committee, while leaving the incriminating portions of the records with the peer review committee where the patient and his lawyer could not obtain copies. The surgeon then had the favorable portion of the records anonymously printed in the *Atlanta Journal/Constitution* newspaper, while also keeping the damaging portion of the record from public view.

The Georgia Court of Appeals was not impressed and they decided the records in the hands of the peer review committee were not privileged from discovery by the patient no matter what the statute on the subject said in the face of such outrageous conduct. The court said that there is "... no reason ... for allowing ... (the surgeon) ... to use the positive findings of the committee to its public advantage against the patient while not allowing the injured patient to review them. The privilege is meant to be a shield, not a sword or a weapon of offense." 364 S.E.2d 70 at 75. Obviously, the moral of the story is that if you are faced with a bad malpractice case, do not turn it into a total disaster by such outrageous conduct. This Court of Appeals decision was handed down before the malpractice case was tried. It is quite likely that more people in Atlanta who were prospective jurors in the malpractice case read about the court's decision in the *Journal/Constitution* or heard about it on TV than the number of people whose minds were swayed by the propaganda planted in the newspaper earlier by the doctors. This is an entree to a record-breaking jury verdict.

*Exceeding Your License* -- In a lecture presented a few years back to an AOA meeting by Dr. Guillette, chief medical officer of Aetna Insurance Co. and John Pacorino, one of their chief
lawyers, these two particularly urged optometrists not to be tempted to engage in activities which are not permitted by the optometric licensing laws in their state. There have been instances where optometrists have prescribed drugs in a non-TPA state through an arrangement with an M.D. who is not in a "controlled environment clinic" with the optometrist. If there is an injury, the first effect is that as to that case all malpractice insurance is void and he will have to pay that claim or suit out of his own pocket. All of the insurance policies provide that they only insure acts which are legal under the local licensing law. Secondly, the courts decide in the malpractice case that he is to be tested by medical malpractice standards, not optometric standards, so it is much easier to lose the malpractice case. In some states, not having the proper license (M.D.) means an automatic loss of the malpractice case. Finally, many optometric licensing laws provide that the license can be cancelled for gross negligence or malpractice and practicing medicine without a license (M.D.) constitutes these, so you also lose your license. The all-over effect is that you lose a malpractice case that an M.D. might have been able to win, you have a huge judgment against you with no insurance to pay it which may cost you your home and clinic, and lastly, you have no license to carry on your own livelihood.

For example, these points are covered in Kime v. Aetna Casualty & Surety Co. 66 Ohio App. 277, 33 N.E.2d 1008 (C.A. Ohio, 1941), Kahn v. Shaw 16 S.E.2d 99 (C.A. Georgia, 1941) and Everett v. State of Washington. 99 W.2d 264, 661 P.2d 588 (1983). The last cited case, Everett, involved a licensed dentist who for years had been a professor of anesthesiology at the University of Washington and had participated in open-heart surgery as an anesthesiologist. Dentists are not allowed to practice anesthesiology except in connection with tooth extraction even though he had become famous for anesthetizing children during open-heart surgery.

In the case of Fairchild v. Brian 354 S.2d 675 (C.A. La., 1977), the defendant optometrist, Dr. Brian, (who was employed by an HMO) was found guilty of malpractice for failure to timely refer a patient to an ophthalmologist. At the HMO when patients called for appointments, a receptionist with no medical training decided from the sound of the complaint whether or not it was serious enough to be sent to a specialist. In the eye clinic the doctors were listed on a bulletin board with no
distinction as to who was an optometrist and who was an ophthalmologist. The appointment makers 
were instructed not to point out these differences to patients either. In December 1973, the 
plaintiff, Mrs. Fairchild, suddenly realized she was having difficulty out of her right eye. She 
called and asked to see an "eye doctor". She was given an admitting slip for January 1974, 
indicating that she was to see a "specialist" who was, in fact, the optometrist, but nothing on the 
paper indicated that he was such. He gave a thorough eye exam and found an opacity in the lens 
which he noted on the chart as "lens changes OD". He saw nothing wrong with the retina of the right 
eye and he diagnosed her condition as early senile cataract. He passed this diagnosis on to the 
plaintiff. She challenged the diagnosis and told him she also had problems with sensitivity to 
sunlight so he recommended that she buy dark glasses. He further advised her that if the cataract 
got worse, it would have to be removed surgically. He testified that he did not examine the 
plaintiff's eyes with a slit lamp because it would require dilation that was prohibited by law. 

There was only one ophthalmologist in the eye clinic of the HMO and because the HMO did not 
want to add another ophthalmologist, there was an internal rule, kept secret from the patients, that 
no patient would be referred to the ophthalmologist until the visual acuity had dropped below 
20/50 or 20/60. He did not refer Mrs. Fairchild to the ophthalmologist. After the January visit, 
she suddenly realized she had no vision at all in the right eye. This time she called in and asked to 
see an ophthalmologist so they changed her regular March appointment accordingly. At that time 
she once again received a slip stating that she was to see a "specialist". The ophthalmologist told 
her that she did not have a cataract, but that she was in deep trouble; in fact, she had a retinal 
detachment that required immediate surgery. The ophthalmologist then sent her home with 
instructions not to drive, bend, stoop or lift anything over 3-4 lbs. He testified at the trial that 
time at the HMO did not allow him to see any patient with early senile cataracts and that he would 
have normally had the optometrist refer this patient to him within the next 3-6 months, 
considering her visual acuity. 

Mrs. Fairchild underwent surgery for the long-standing (ascertained by the demarcation lines) 
retinal detachment and was also treated for von Hippel-Lindau disease. The latter condition caused
another detachment which required a second surgery. However, some residual detachment still existed and the plaintiff was unlikely to ever regain normal vision in that eye. The court found that the optometrist had exceeded his license when he had diagnosed cataracts and "treated" them with dark glasses and had failed to refer her to an ophthalmologist. By this action he was, therefore, subject to the same rules relating to the duty of care and liability as the ophthalmologist. This negligence caused a retinal detachment to not be discovered until it was too late to save the sight of the eye. The point this case makes is that the scope of optometry permitted under the particular state's licensing laws cannot be exceeded without potentially being found to be practicing medicine and held to those standards, instead of an optometric standard, should a claim be made.

**General Practical Hints**

The remaining sections of this paper discuss various general practical hints that may help minimize the possibility of a claim in a number of aspects of optometric care. They are offered merely as suggestions, not as a statement of how to practice optometry or manage the office. The following discussion mentions potential sources for claims and suggestions to help bolster a defense in the event of litigation. This paper does not purport to list every detail nor to discuss every potential area where a claim could be made. These sections are not necessarily based upon any particular cases or decisions made within any specific jurisdiction. Rather, they are ideas presented to the reader for consideration and to stimulate thought on the reader's part of how he might minimize or eliminate possibilities of claims being made within his own office. Illustrative cases in certain areas are included to give the reader an idea of how courts have ruled in the past and to help identify the major problem areas up to this point in time.

**Contact Lenses** -- Potential liability is associated with every aspect of the fitting, follow-up care and continued regular vision service for the contact lens patient and the optometrist should keep this in mind as he manages this patient population. Proper patient selection is very important in terms of minimizing risks of liability. Before recommending contact lenses to a patient the optometrist needs to evaluate all of the information obtained during the examination to ensure that contact lenses are, in fact, an advisable option for the patient. Does the individual display
reasonable dexterity to be able to handle contact lenses? Are there any significant indications that
the patient would disregard lens hygiene altogether or fail to comply with minimum lens handling
and cleaning and cooperation to permit necessary follow-up services? Does the patient work or
spend a significant amount of time in an environment where contact lenses are inappropriate such
as a chemical lab with noxious fumes or an outdoor occupation in dry, dusty environs? Has the
exam revealed any current ocular conditions that contraindicate the use of contact lenses or make a
certain lens design a poor choice for refractive correction? Any systemic disease or medication
elicited in the case history that may affect the eye or be exaggerated by contact lens wear must be
considered. It should also be established whether there has been any prior sensitization or allergy
to an ingredient (preservative or cleaning agent) in a solution necessary in the care of the lenses to
be prescribed.

**Fitting** -- The fitting process can also be fraught with potential sources for litigation. First
of all, the patient should be instructed about the risks and benefits of contact lens wear in general
and certain types (hard, soft, gas permeable) in particular, the responsibilities he will have to
assume as a patient, the time involved in follow-up care and a brief description of what will happen
during the fitting process (when a diagnostic trial fit is performed). Also, the realistic probability
of success with contact lenses, any prevalent conditions or borderline findings found during the
exam and other alternatives to contact lenses (such as spectacles and bifocals) should be discussed
with the patient prior to contact lens fitting. If bifocal contact lenses are to be prescribed, the
patient needs to be informed of the different types, the risks and benefits as compared to bifocal
spectacles and particularly in the case of monovision contact lenses, the individual must be warned
about the likely decrease in depth perception, peripheral vision and compromised visual acuity
-especially while driving or operating equipment). Tinted contact lenses, particularly when
they cover the pupillary area, can diminish night vision and this information must be passed on to
the patient. In the case of extended wear lenses, the increased risks of corneal infections, ulcers
and other corneal complications with these lenses should be impressed upon the patient. In any of
these situations, whether it be regular daily wear or a special lens design, avoid making
direct or implied guarantees of either the materials or services. If the optometrist does, he may be held to it by a court. Hence, do not promise the patient a successful contact lens fit.

If the practitioner is a registered clinical investigator for a contact lens company, he needs to obtain an informed consent from the patient. The purpose and procedure must be adequately described, the experimental nature explained, the potential risks, discomfort and benefits expected need to be stated, as well as the alternative procedures that are available and the fact that the patient may withdraw consent and not continue with the project at any time. In this case there should be a signed written informed consent and one copy given to the patient while the other is retained in the patient's file. In the other instances, a written informed consent is not necessarily mandatory (although there should be documentation in the record that the risks and benefits were discussed with the patient and patient responses should be noted), but it is advisable. These written forms should not contain any statements waiving the patient's legal rights or any other exculpatory language. In addition, they should be written in layman's terms and not in optometric jargon so no question can be posed as to whether there was valid, understandable informed consent (examples of contact lens forms are included in Appendix A). Another form specifying the fee schedule, refund policy and what services will be provided and signed by the patient is recommended to avoid any possible misconceptions regarding payment. Finally, a fitting technique and/or lens selection that is too individualistic can potentially be considered as too great a departure from the accepted methods and should be utilized with caution.

The potential liability that may be incurred during the diagnostic fit include corneal abrasions, injury to the cornea or sclera during lens application or removal or an allergic or chemical sensitivity to a contact lens solution ingredient. The best way to minimize this potential source is to inform the patient of the remote possibility of this occurring and also making sure that visual acuities and any prior ocular conditions, particularly any staining or corneal scars, are documented as present before any contact lens is applied.

**Dispensing** -- The crucial aspect during dispensing is patient education and failure to adequately carry this out can have serious legal implications. To begin with, an appropriate
wearing schedule designating the number of hours the contact lenses are to be worn each day and the appropriate increase in wearing time need to be stated verbally, as well as in written form on a fitting agreement so the patient can refer back to it. Instructions on application and removal of the contact lenses are mandatory and it is best to have the patient demonstrate reasonable proficiency in lens handling before he leaves the office. The appropriate lens storage, cleaning and disinfecting systems should be discussed and it is advisable to have the patient repeat the procedure back to the practitioner or assistant to ensure proper patient understanding.

The patient should also be informed that utilizing solutions and cleaners other than those recommended for his lenses may cause lens damage and eye irritation and he should consult his doctor before substituting any of these preparations. The additional risks of unpreserved saline, particularly homemade saline, and the possibility of Acanthamoeba infections should be emphasized. Daily wear soft patients should be informed that their lenses are not to be used as extended wear lenses and doing so may potentially compromise the health of their eyes. The warning symptoms, including any unusual redness or pain and a decrease in vision, should be described and the patient needs to know that he must remove the lenses, call the optometrist and come in for an exam before continuing to wear the lenses. Providing the patient with the office and an emergency or home phone number are a good idea.

The importance of follow-up exams should be stressed and appointments made and written down for the patient before he leaves. The patient needs to understand that he may experience contact lens complications that may go undiagnosed with serious consequences if he does not cooperate with the follow-up care. The contact lens patient is involved in a comprehensive long-term treatment program and he should be made aware of this responsibility. The contact lenses are not merely a consumer item, and rather, require a cooperative relationship between doctor and patient over a period of time to ensure successful wear. The possible complications should be discussed with the patient so he has an idea of what can go wrong and the importance of returning to the office should any of these develop. All of the above need to be written down on a fitting and follow-up care agreement form, signed and dated by the patient and a copy retained in the record. Another copy is
given to the patient for his reference. Patients often remember only a small portion of the information presented to them and a written form with the wearing schedule, solutions to be used, an outline of the care system, warning symptoms requiring attention and the follow-up appointments is essential. Failure to do so would expose the optometrist to an unnecessarily high risk of potential malpractice and little means of proving that he exercised due care in dispensing the lenses.

Extended wear lens patients should be instructed not to exceed the recommended continuous wearing time, informed of the greater risk of complications they incur due to extended wear and that they should not sleep in their lenses. If they experience cloudy or foggy vision, pain, redness, or a decrease in vision, they should report back to the optometrist immediately. In addition, the possible necessity of returning to daily wear, the unpredictability of extended wear lens life and the potential need to replace the lenses more often than anticipated must be explained to the patient. All of this should be in writing on the fitting agreement form. Bifocal, especially monovision, contact lens patients should have a warning given both verbally and in written form regarding decreased depth perception, peripheral vision, possible problems in the intermediate range and reduced visual acuity. A demonstration of these effects by wearing the contacts in the office is a good idea. Patients who drive or operate dangerous machinery should be particularly warned and alternatives such as spectacles over the contacts or a third contact lens for distance in such circumstances should be discussed with the patient and documented.

Prepaid service agreements are advisable and they provide specified services at no additional charge for the covered period and often a lower lens replacement cost. Since the patient has already prepaid, he is more motivated to return to the office in the event of any difficulties with the lenses and can promote cooperation with the follow-up regime.

**Disposables** -- Disposable contact lenses pose a new area for additional risks. With these lenses, improper lens care that often leads to deposit buildup and infections is theoretically eliminated since the lenses are disposed of in 1-2 weeks. Also, patients do not have to comply with lens cleaning and disinfecting instructions since the system is based on replacement rather
than care. However, how can the practitioner be certain that the patient is adhering to the replacement schedule? This, together with shipments to the patient without requiring the follow-up care prior to receipt spell potential disaster. Retaining these lenses for longer periods of time than prescribed, along with no patient education on cleaning or disinfecting can create a potential breeding ground for infection. 16,17 In the event of complications and litigation proceedings, the optometrist would find himself with a poor defense since he neglected to perform follow-up exams and failed to monitor the patient adequately. This does not mean that the disposa lens system should never be utilized, but a word of caution needs to be given. Keen attention to follow-up care and stressing to the patient the importance of adhering to the replacement schedule, along with a description of possible complications if they do not, are vital. Having this information printed on the fitting agreement form and signed by the patient is, once again, highly advisable.

**Follow-Up Care** -- As can be inferred from the above discussions, failure to provide follow-up care nearly invites a liability claim. Although many contact lens patients experience no complications and successfully wear the lenses, one cannot rely on this. 18,19,20,21,22 After all, the famous addage of Murphy's Law, "if anything can go wrong, it will", is not so often quoted without reason. The patient needs to be informed of the reason why follow-up exams are vital and ideally, they should be scheduled prior to the patient leaving the office. Providing an appointment card with the date and time, as well as including it on the fitting agreement are excellent ideas. Also, provide the patient with the office and an emergency or home phone number to encourage the patient to phone the optometrist in the event of any experienced difficulties. If the patient fails to appear for the appointment, this fact should be documented in the record.

A number of practitioners feel that their responsibility ends here and although it may be adequate in some cases, there is no assurance that a jury will view it in the same manner. An attempt should be made to phone the patient, ascertain the reason why he failed to return and try to persuade him to come in by discussing the reasons why it is so important. The phone call and notes on comments made on both sides of the conversation should be included in the patient's file,
probably on an extra sheet of paper and dated. Failure of the optometrist to be available during this follow-up period should the patient experience symptoms and calls unexpectedly may be considered "abandonment of the patient" and would be deemed as professional negligence. The patient may wait, continue attempting to reach the optometrist and allow the symptoms (and potentially the damage) to increase or seek another eye care professional and in both instances, the practitioner exposes himself to a likely count of malpractice.

Another area that has in the past led to a malpractice claim where the eye care practitioner lost the case is failure to provide regular comprehensive exams. Follow-up care and fitting when new lenses are dispensed are crucial, but a regular exam that examines overall eye health, visual fields and tonometry are just as important. There is one case on record where a practitioner only provided contact lens care and neglected to perform tonometry over a number of years until finally another professional discovered that her symptoms were due to glaucoma and not contact lens problems. Therefore, never neglect performing regular comprehensive visual exams and potentially allowing a pathological condition to go undiagnosed. This is an unnecessary exposure to a malpractice claim that can be avoided.

Product Liability -- The product liability issue in the past has not applied to contact lenses since hard contacts were not finished products provided to the public in regular channels of trade and were not themselves defective. The same will probably hold true for gas permeable lenses because they are also modified to fit the individual patient. Soft contact lenses, however, are dispensed without making any modifications and may apply to this rule. The verdict remains to be given in the courts. This would allow the contact lens manufacturer to be named a defendant, along with the practitioner, and the jury or plaintiff-patient may name either or both as being held responsible in the event the patient wins. Usually the "deep pocket rule" is followed, but there is no guarantee this will be the case every time.

The responsibility of the practitioner is to provide continuous care periodically as necessary to all patients, including contact lens patients. If the optometrist wishes to terminate care or the patient leaves the practice, the patient must be notified, referred to another doctor and a complete
copy of the patient’s file sent to the new doctor. The reason for termination, to whom the patient was referred and the date the records were sent must be documented. Failure to adhere to this procedure may result in a claim involving "abandonment of the patient".

A case involving contact lenses is that of *Barbee v. Rogers*, 425 S.W.2d 342 (Su. Ct. Tex., 1968). Here a plaintiff alleged injury to his eyes from improperly fit contact lenses. They had been refit several times, but they still bothered his eyes. The status of the three defendants is a little unusual. Texas State Optical, Inc. is a manufacturing corporation in the business of making contact lens blanks. Most or all of the stock of this company is probably owned by defendants Jay Rogers and S.J. Rogers, both of whom are licensed optometrists. These two optometrists have a partnership under the name of Texas State Optical (unincorporated). Texas State Optical (the partnership) is the largest optical retailer in the state of Texas and employs legally 125 optometrists, in addition to the owners. Thus, in effect, its appearance would be different and its size is much larger, so in reality it could be said to be the largest optometric clinic in the state.

The plaintiff went to one of their outlets seeking contact lenses. He was fit with lenses, the blanks for which were made by Texas State Optical, Inc. with the finishing done by the optometrists employed by Texas State Optical (unincorporated). The essence of the plaintiff's complaint was that the curvature of the contact lenses did not match the corneal curvature. Texas State Optical refit them several times without charge, but the lenses still did not fit properly. After 16 months they were still not fit properly and the plaintiff stopped wearing them and moved to California. He experienced various continuing ocular symptoms. He then went to an ophthalmologist in California who determined that his eyes were permanently damaged, whereupon he sued Texas State Optical, Inc. and the two Rogers brothers as partners in Texas State Optical (unincorporated). The fitting had been done by optometric employees of the partnership, not the Rogers brothers personally. Basically, the plaintiff sued all the defendants on all possible theories of legal liability. He sued Texas State Optical, Inc. as a manufacturer of a defective product for breach of warranty. On this theory, he would not have to prove negligence on the part of the defendant, but just that they had put a defective product out on the market.
His real problem was that he did not know what specific act of negligence made the contact lenses fit so poorly. He sued Texas State Optical (unincorporated) on a breach of warranty theory for putting the defective product out on the market as a retailer and as an alternative, sued them for negligence in actually doing the fitting of the contact lenses.

After a full trial, the jury found that Texas State Optical, Inc. did not put out a defective product on the market since the blanks were not defective and thus, there was no ground to sue them and they were dismissed. It should be noted that all of the specific acts alleged by the plaintiff that he had some evidence for related directly to either the prescription, the actual fitting, refitting or modification of the lenses. As against Texas State Optical (unincorporated) the jury found that the lenses did not properly fit the plaintiff's eyes and they were negligently modified, but that this was not the cause of the plaintiff's injury. The jury also found that the lenses were not within the warranty for reasonable fitness of use which caused his injury (breach of warranty theory -- negligence need not be proven, but the product must be defective) and awarded him $10,000 from Texas State Optical (unincorporated).

The defendants appealed to the Texas Court of Appeals and this court held that the case was a malpractice case and the contact lenses were not defective and therefore, the jury verdict was illegal because the plaintiff had not proven negligence or breach of the professional duty of care of optometrists. The plaintiff appealed to the Texas State Supreme Court and they decided that the Court of Appeals was correct and affirmed the judgment. The only right way to try this case would have been as a malpractice suit for optometric care which the plaintiff failed to prove on every possible alternative. Furthermore, the Texas Supreme Court decided that contact lenses were not a product which could be a subject of a breach of warranty suit (unless possibly the blank itself was defective). Therefore, the plaintiff received nothing.

You may be wondering how far the optometrist must go in doing all the contact lens modifications himself. In order to answer this question a careful examination of the licensing laws in the particular state you are interested in and the relevant cases is necessary. For example, in Illinois the Supreme Court has held that contact lens fitting and modification must be done by
someone licensed to practice optometry or medicine and surgery. *People v. House of Vision* 77 ALR.3d 809 (Su. Ct. Ill., 1975) Compare this to Pennsylvania where in the case of *Commonwealth v. Stemet* 21 Pa.2d 295 (Pennsylvania, 1959) the court held that this matter is not a professional function and can be performed by opticians. A third approach to this problem is that used in the state of Massachusetts. In the case of *Attorney General of the Commonwealth of Massachusetts v. Kenco Optical, Inc.* 340 N.E.2d 888 (Massachusetts, 1976) it was held that duly licensed dispensing opticians can fit and modify contact lenses. Therefore, one has to consult the particular state laws pertaining to this matter of whether only optometrists and physicians or also opticians can fit contact lenses.

*Use of Pharmaceutical Agents* -- As of 1989, nearly half of the states authorize optometrists to use therapeutic pharmaceutical agents (TPAs) and all the states now permit the use of pharmaceuticals for diagnostic purposes. In the past malpractice claims primarily involved misdiagnosis and the failure to use diagnostics resulting in a pathological condition going undetected and untreated. There is a potential for liability in misuse of the drugs, but more often than not, claims were made based on failure to use. In the realm of therapeutics, future claims will probably be associated with misdiagnosis and the application of the right treatment for the wrongly diagnosed condition. This does not mean that a suit involving an inappropriate treatment regime is not possible. Misdiagnosis, along with drug complications (especially those involving topical steroids and miotics) were the leading causes in a study reviewing claims in ophthalmology.

The passage of the TPA laws are rather recent in most states and therefore, if there are pending claims, enough time has not elapsed for a judgment to be made, the decision to be appealed and the case to be listed in the law references. We must instead look at the experience of ophthalmologists for an idea of potential sources of litigation.

*Diagnostic Agents* -- Let us first focus on these drugs, since some of these can potentially be more toxic and more harmful than the therapeutic agents. The risks with the use of topical anesthetics are rather small, but should not be overlooked. A history of any prior adverse reactions should be elicited and this information or a note stating a negative history should be
documented in the record. Applying the anesthetic with the knowledge of a known previous adverse response opens the door for a potential claim. An anesthetic with a different chemical structure should be utilized instead. If an allergic response occurs with no prior history and no possibility for the doctor to have known, then no liability is likely to be incurred. The reaction should be documented and the particular anesthetic should be avoided in any subsequent exams. Repeated application of the anesthetic or permitting the patient access to its continued use over a period of time is an invitation for liability.

In the case of mydriatics, a thorough case history should be taken to ascertain whether there have been any prior adverse reactions, including any prior angle closure. Anatomically narrow angles should be dilated with caution and the patient informed of the potential consequences and the symptoms of angle closure. However, the risk of not dilating and allowing a retinal disease to go undiagnosed is generally considered an even greater danger so this condition does not preclude dilation. 27 With cardiovascular conditions the practitioner would probably be well advised to avoid the use of phenylephrine. 27 Any known allergic response, of course, indicates the use of a different mydriatic. Prior to instillation, a discussion with the patient regarding the reason for dilation, the procedure, the adverse effects of blurred vision, decreased accommodative abilities and photophobia, duration of these effects and the potential for angle closure needs to be made. The patient should be warned not to drive while the pupils are dilated and vision is somewhat impaired, and ideally, try to have someone else take him home. In the event of a vehicular accident where the patient drove while dilated, the optometrist will in most instances be held liable.

Before drug instillation, the depth of the anterior chamber and the IOP should be measured and documented in the record. Following the dilated fundus exam, it would be recommended to recheck the IOP and enter it into the record. If the IOP is significantly elevated, the patient should be asked to remain in the office to enable monitoring of the pressure. The patient must be informed of the warning symptoms of angle closure and be given a number to call if they should experience any of them. The elderly and handicapped should be given special assistance until they leave the office and cautioned to be careful while walking or moving around until the mydriasis wears off. Should they
stumble and fall, the injury will be considered due to the impaired vision during dilation and the optometrist will be liable. [A side note here needs to be added regarding falls or tripping. If a fall is found to be due to inadequate instructions concerning the proper use of a new prescription, liability could also ensue. This includes the first time bifocal wearer or a new high cylinder correction. Both require adaptation and potential difficulty in the beginning and the patient must be so informed.]

With regard to cycloplegics, once again pre-instillation visual acuities, case history, anterior chamber angle evaluation and IOP should be documented and any contraindications should be taken into consideration. Be careful as to dosages and concentrations with very young children, especially should atropine be used for some reason. 28,29,30

One case illustrating failure to dilate with diagnostics in order to obtain an accurate spectacle prescription for a young child is that of Kahn v. Shaw 16 S.E.2d 99 (C.A. Georgia, 1941). A ten-year-old boy was seen by an optometrist who prescribed corrective lenses which were worn by the plaintiff for several weeks. The boy developed severe headaches, nausea and a deep-seated pain in his eye so he returned to the optometrist and was reexamined. The doctor reconfirmed his findings and told the patient to continue wearing the glasses and within a short time the headaches and nausea should subside. The boy wore the glasses for an additional week to ten days, but the symptoms continued.

The mother then took him to an ophthalmologist who dilated and found that a significantly different prescription was needed. He testified that the glasses prepared by the defendant were not suited to the plaintiff's eyes, were not corrective and were highly injurious. He further stated that for any person of the age of the plaintiff it was necessary to dilate in order to prepare corrective glasses. He went on to say that the boy's eyes were injured permanently and the proximate cause was the defendant's careless and negligent acts. The jury did return a verdict for $200 in favor of the plaintiff, but the amount was very small and in essence, reimbursed the plaintiff for the improper glass prescription.

Another case involving the use of diagnostic agents is that of Graham v. Whitaker 282 S.C.3d 3, 41
The 77-year-old plaintiff went to an ophthalmologist to be examined for glaucoma. She was called into the exam room where the doctor instilled drops in her eyes and then left the room with no explanation or warning as to the possible side effects of the drops. The lady was left in the hands of an assistant with no medical training and also did not warn her about the side effects. The patient sat in the chair and then noticed that her vision was extremely blurred. She called out and at the same time stood up and fell. She struggled up, but fell twice more because her foot was wrapped around the chair. Her husband took her to the hospital emergency room and an x-ray showed that she had a fractured hip. A pin was inserted, but the bone eroded and a second operation was necessary for a total of 101 days in the hospital.

In court the packing slip for Mydriacyl, which warned of blurred vision and possible dizziness (the extent of which varied from individual to individual) provided evidence that the plaintiff should have been warned of the potential side effects of the drops. It was also determined that none of Dr. Whitaker's "nurses" had any medical training prior to joining his staff and this lack of training included any rudimentary knowledge of first aid, as well as any knowledge in the field of ophthalmology. Another issue was whether leaving an elderly person with possibly blurred vision in the care of an unskilled medical attendant would constitute reckless conduct for which punitive damages could be awarded. The jury found that there was negligence in the failure to disclose potential side effects, as well as reckless conduct when the patient was left with untrained assistants and the verdict included $10,000 for actual damages and $10,000 for punitive damages. The judge also announced that he would grant a new trial unless the defendant agreed to an additional amount of $67,000 for a total of $87,000. This case illustrates the importance of explaining to the patient the potential effects he may experience upon dilation.

Therapeutic Agents -- Let's now focus on therapeutic drugs. As was mentioned earlier in this paper, drug complications constituted the leading category among a study of claims against ophthalmologists. Of these, the majority involved steroids, miotics and carbonic anhydrase inhibitors. The following will briefly point out some of the adverse effects and cautions in the use of typical TPAs. It is in no means to be considered exhaustive, but it should give an indication
of what types of problems to look out for and above all, the need for caution. Of course, allergy and medication history are extremely important and must be elicited prior to the start of any treatment regime.

Corticosteroids can cause potential adverse effects with all preparations and with all routes of administration and the incidence of these effects is usually related to dosage and length of treatment. Steroids should be used with extreme caution in patients with diabetes, infectious disease, congestive heart failure, chronic renal failure, hypertension and glaucoma. Drugs such as rifampin, barbiturates, phenylbutazone and phenytoin reduce the anti-inflammatory and immunosuppressive effects of steroids. In turn, steroids reduce the effectiveness of anticoagulants. Practitioners need to be aware of these interactive effects and inform patients accordingly.

Adverse effects of anti-infective agents need to be kept in mind as well before instituting them in a treatment program. Allergic reactions are the major drawback of the penicillins and in such cases, consider substituting erythromycin unless contraindicated. Cephalosporins cause hypersensitivity reactions in 5% of patients and excessive doses can potentially cause renal damage. Bacitracin should only be utilized topically due to its severe nephrotoxic effects if used systemically and the same is true for systemic use of polymyxin B. Systemic administration of aminoglycosides can potentially produce ototoxicity and nephrotoxicity. Neomycin often causes hypersensitivity reactions with topical administration and frequently it is wise to substitute its use with a comparable, less sensitizing drug. Avoid the use of tetracyclines during pregnancy, as it can cause depressed bone development in the fetus and discoloration of the permanent dentition. Chloramphenicol has been known to depress bone marrow and cause aplastic anemia in some instances and substitution of other equally effective drugs is highly advisable. The major cautions with the sulfonamides are hypersensitivity reactions, exacerbation of Stevens-Johnson syndrome and the contraindication if a marked purulent infection is present.

The antivirals and antifungals should be used with caution just like with the antibacterials above. Avoid the use of vidarabine during pregnancy due to its potential mutagenic and carcinogenic
Acyclovir may be a good alternative since it is associated with minimal side effects and does not interfere with corneal healing. The antifungals, nystatin and amphotericin B, are both nephrotoxic, must be utilized with caution, and are strongly contraindicated in patients with renal insufficiency. 27,31

Anti-glaucoma agents all have potentials for complications. Timolol, the most commonly prescribed beta blocker, is contraindicated in cases of congenital glaucoma, narrow angles, diabetes, chronic obstructive pulmonary disease and heart block. 27,31,32 Betaxolol is safer for patients with respiratory problems, but often these individuals, along with those with cardiovascular difficulties, should be placed on alternative anti-glaucoma agents. Prescribing without consideration of these contraindications is an invitation for adverse consequences and liability. Miotics have frequently been involved in claims. 24 Patients with high myopia, prior retinal detachments or lattice degeneration should not be treated with miotics unless absolutely necessary. 27,31,32 In that event, the patient needs to be informed of the possible complications, the warning signs of detachment and to immediately seek professional attention if that occurs. A dilated fundus exam both initially and periodically during treatment are very crucial. Failure to heed these precautions once again constitutes negligence. Miotics can also potentially precipitate asthmatic attacks and therefore, warn susceptible patients accordingly. Patients using miotics in general should be informed of potential decreased visibility at night, particularly while driving.

Carbonic anhydrase inhibitors are yet another group of drugs eliciting a number of claims. 24 Individuals with hypersensitivity to sulfonamides should not take carbonic anhydrase inhibitors. Those with impaired renal function, cirrhosis of the liver, chronic obstructive pulmonary disease, sickle cell hemoglobinopathies and pregnancy are contraindications. 27,31,32 These inhibitors also prolong the effect or increase the activity of amphetamines, quinidine, tricyclic antidepressants and salicylates, and the patient should be so informed.

In regard to all the therapeutic drugs, the patient needs to be informed concerning the reason for its use, any necessary precautions the person should take, potential side effects and their severity and a reasonable prognosis. Any drug contraindications need to be taken into account prior
to any treatment. Any deviation from the recommended uses and amounts listed in the Physician’s Desk Reference or utilization despite known contraindications need to be documented regarding the reason why and should be explained to the patient. Make sure that the benefits do indeed outweigh the risks. Failure to utilize the drug properly or lack of an adequate informed consent will result in liability should litigation ensue.

The following case involves a treatment situation where the doctor won. In *Winkjer v. Herr*, 277 N.W.2d 579 (Su. Ct. N.D., 1979) an unusual set of facts and a difficult decision-making posture for a treating ophthalmologist or optometrist in a TPA state (allowing optometrists to treat glaucoma) is presented. The ultimate issue here is whether or not the ophthalmologist in this case was negligent in concluding that the patient had glaucoma and instituting treatment with drugs (1% pilocarpine, 0.03% and 0.06% phospholine iodide) which had a side effect of causing cataracts and in fact, did later cause cataracts. He had the following facts available to him at the time he made the decision to begin treatment. The patient had chronic high IOP, but no observable damage, the patient was myopic, and the patient’s mother had suffered from glaucoma. The drug treatment began with pilocarpine 1% and then was switched to 0.03% bid phospholine iodide. After that it was changed to 0.06% qd phospholine iodide and then back again to 0.03% bid phospholine iodide.

Eventually this drug treatment did cause cataracts which were removed surgically. The plaintiff received a second opinion from a glaucoma specialist at the Mayo Clinic after the drug treatment had been going for a considerable amount of time and before the cataracts were significantly developed. His opinion was that the drug treatment should be completely discontinued and the patient simply monitored as an ocular hypertensive. In a deposition he stated that his opinion was based on the following -- namely that the patient had combined difficulty from taking phospholine iodide and the development of cataracts. He felt it was better to take a chance on glaucoma and let the plaintiff see better until such time as cataract surgery might be necessary. He specifically stated that he did not disagree with the diagnosis of glaucoma made by the defendant, although it was uncertain at the time made. The defendant ophthalmologist elected to adopt the reverse treatment, of course. However, he vacillated in his medical opinion. At the same time he
had diagnosed the plaintiff as having glaucoma based on the facts reviewed above, he also wrote a letter to the Federal Aviation Administration (the plaintiff was a pilot) stating that his diagnosis of the plaintiff's condition had changed from chronic open angle glaucoma to ocular hypertension. If that were true, he should have probably dropped the drug treatment.

Although the case was eventually decided upon some legal technicalities, the Supreme Court of North Dakota stated that in this situation a medical professional could not be held liable because he had prescribed the correct drug for the actual condition, although his diagnosis was erroneous. The conclusion to be drawn from this case is that if the treatment is correct for the actual condition shown to have occurred over the passage of time, it does not matter that the doctor made a misdiagnosis in the course of prescribing the drug.

An area where an optometrist may be vulnerable is in cases where systemic drugs present ocular symptoms. Let us now look at several examples of such a situation. In the coincidental event case of Bailey v. Sturm 59 Wis.2d 87, 207 N.W.2d 653 (Su. Ct. Wisc., 1973) the patient-plaintiff had a reaction to novocaine given by a dentist which caused pain in the left eye, diplopia and blur. The patient then went to an ophthalmologist 18 days later complaining of trouble with her eyes, but no abnormalities were found and a clip-over prism was prescribed. Three days later she went to a family physician due to headaches, blur and diplopia and three days after that, she consulted a neurologist because she had ptosis, was unable to move the left eye and had decreased sensitivity in that eye. The neurologist thought it might be due to a toxic neuritis and prescribed vitamin B supplements. Sixteen days later she was still experiencing headaches, diplopia and reduced visual acuity so Darvon was prescribed and she was scheduled for elective surgery in two weeks. Instead, she went to see a surgeon and nine days later she was hospitalized due to lost sight in the left eye, proptosis and the fact that the eye was now fixated for 40 days. The surgeon, as well as the neurologist, examined her and decided to have a neuro-ophthalmologist (Dr. Sturm) come in for a consultation. Eight days later, Dr. Sturm operated to remove a mass behind the eyeball and in the process, severed the optic nerve. Later it was found to be a pseudotumor due to inflammatory swelling.
The patient sued for improper care and treatment in the hospital, for surgery and severing the optic nerve, but not for the office work outside the hospital. The lower court jury decided that Dr. Sturm was not guilty of malpractice, but the surgeon was found negligent for not differentiating between a tumor and an inflammation. The trial court gave a verdict for $15,000 and the decision stated that there had been a failure to have the tumor examined by a pathologist before the optic nerve was severed, a failure to properly treat the condition discovered during the surgery and negligence in not consulting with the dentist.

The Supreme Court of Wisconsin on appeal determined that in reality the neurologist had misdiagnosed the condition in his office when he thought it was toxic neuritis and had prescribed vitamin B supplements. The patient had only sued for the hospital work, not the office work. The surgeon shared an office with the neurologist, but partnership could not be proven. He had corrected the misdiagnosis of the neurologist, but he went on to make the mistake that the bulge was a tumor. An expert witness stated that the basic negligence here was the failure to try drugs (steroids) prior to surgery based on the symptoms of proptosis, paralysis and continued loss of vision. It was held that there was no causal connection between the loss of sight which occurred nine days before and the severing of the optic nerve (sight had already been lost nine days prior). Secondarily, it was found that the surgeon should have either performed a biopsy or put the patient into the hospital earlier on an emergency basis. The Supreme Court affirmed what the trial court had found.

Another case of ocular symptoms caused by a systemic drug is the case of Reed v. Church 8 S.E.2d 285 (Su. Ct. Vir., 1940). Here the plaintiff's injuries were caused by negligence of the doctor (general M.D.) in carrying out a long course of treatment of injections of tryparsamide for hypertension. The problem here was that the drug was injected every 4-5 days over a long period of time, but after the third injection, the plaintiff had told the doctor that the treatments were affecting his eyes. The doctor had told him that when they were through, the symptoms would clear up. The plaintiff repeated this complaint on many subsequent visits to the doctor's office for injections. The doctor had literally told him that "your blindness will clear up". Reed v. Church 8
Tryparsamide was a new drug as of 1937 and was extensively reviewed in the medical literature (as the expert witness revealed) which all stated that the drug was to be discontinued if ocular symptoms occurred. The packing slip furnished with the drug devoted two full pages to ocular disturbances which also recommended discontinuation immediately if ocular symptoms appeared.

After approximately seven weeks of injections, 4-5 days apart and continued decrease of vision, the plaintiff went to an optometrist, as well as an optometric neurologist and a third doctor, an EENT specialist. All three informed him that he had permanent atrophy of the optic nerve. The EENT specialist called the general M.D. and not only suggested that he discontinue the drug (nine injections to date), but that he undertake another drug treatment designed to offset effects of tryparsamide and stop further deterioration of the optic nerve. Unfortunately, by this time the patient had "gunbarrel vision" (only a central island of vision) with no prospects of improving. The patient was unable to work or to get to the doctor's office by himself (he was almost blind according to the court), and a review and examination of the patient by the Johns Hopkins Hospital in Baltimore confirmed all this and indicated that there was no hope of improving vision.

Dr. Reed (the general M.D.) had been his doctor for over 20 years and knew the plaintiff had syphilis 20 years before. The doctor told the plaintiff some 14 years before this course of treatment that he had been cured of syphilis. At trial it was claimed that the syphilis was the cause of the loss of vision 14 years later and that a fainting spell two weeks before the tryparsamide treatment was begun was caused by syphilis. However, Dr. Reed furnished a written medical opinion at that time stating the cause was hypertension.

The significant issue in this case is whether the treatment with the drug or syphilis caused the atrophy of the optic nerve and blindness. The doctor encouraged the plaintiff to ignore the symptoms he complained of repeatedly when injections were given and even tried to tell him that the blindness would go away upon completion of the course of treatment. Under the contributory negligence law then applicable in Virginia, the plaintiff would not have recovered anything if his actions partially caused the blindness. At trial the jury found the doctor liable because he had failed to discontinue the
treatment after the first or second complaint, that he knew or should have known, from the medical literature alone, to watch out for ocular symptoms when using the drug and to discontinue treatment immediately if any ocular symptoms appeared. The plaintiff was induced to become virtually blind due to the doctor's reassurances that the eye condition was reversible. It is interesting to note that this doctor never claimed that during the nine visits for injections and six instances of complaints of ocular symptoms that the symptoms were caused by anything besides the drug. The syphilis seems to be an invention shortly before trial.

The trial court awarded a judgment to the plaintiff for his blindness and after a thorough review of the evidence, the Supreme Court of Virginia affirmed this judgment. It is important to note that in so doing the Supreme Court of Virginia made a special point of stating that a doctor's duty includes being familiar with the medical literature (in this case pertaining to drugs), but that he is not an insurer or even held to the highest degree of care known in his profession with respect to the medical treatment of his patients. The court went on to say that "the mere fact that he has failed to effect a cure or that his treatment has been deleterious will not raise a presumption of his negligence. He (the doctor) must only exhibit the degree of skill and diligence employed by an ordinary prudent practitioner in his field and the community ... ". Reed v. Church 8 S.E.2d 285 at 288 This is a universal rule applied in all states whether the "community standard rule" or the reasonable physician standard rule is used. In this case, the doctor testified that he had read the medical literature on the drug and was aware of the warnings of ocular symptoms contained therein, and further that, he had read the packing list with the two pages of ocular symptoms prior to this course of treatment. He also admitted being aware from both sources the importance of immediate discontinuation of treatment if any ocular symptoms appeared. Not only did he not do so after the six complaints, but he affirmatively told the patient that at the end of the course of treatment the ocular symptoms would reverse themselves. At the time of that statement the patient was nearly blind and nine treatments had been given. The defendant was a general practitioner, who it could be said with respect to this drug, was in a similar position to optometrists who went to school prior to consideration of TPAs, although this doctor claimed to have read the literature on the subject. It is
important to remember that 2/3 of all medical malpractice cases actually tried are won by the doctors. In this case where the doctor lost is a clear example of outrageous conduct during the course of treatment. There were plenty of opportunities to stop the treatment when ocular symptoms could have been minimal, instead of after near total blindness.

As the reader can see, an area that optometrists should be gravely concerned with are ocular reactions to systemic drugs prescribed by a non-eye care professional. This is exactly what happened in the case of *Johnson v. Winthrop Laboratories* 190 N.W.2d 77 (Su. Ct. Minn., 1971). The plaintiff went to an ophthalmologist stating that she needs glasses, but she made no correlation to the drug (Aralen or chloroquine) that she was taking and her ocular symptoms. For 12 years a dermatologist had prescribed Aralen for lupus erythematosis. Her visual difficulties had been first noticed in 1960, although they were minor at that time. By 1962 the symptoms were a little worse and by 1963 she had blurred vision to the point that she could not recognize people. She had consulted Dr. Sterner, an ophthalmologist, on three occasions in 1960 and then Dr. Schmidtke (an ophthalmologist) on two occasions in 1963. The glasses prescribed by the first ophthalmologist did not improve her vision and therefore, she switched to Dr. Schmidtke. The plaintiff had been treated by Dr. Lynch, the dermatologist, for the same skin condition with chloroquine from May 1954 to March 1964. She had complained about the declining vision in 1960, 1962 and 1963, but he did not stop the chloroquine till March of 1964. It is important to note that on many occasions in this ten-year course of treatment she had an appointment with Dr. Lynch, but on arrival she would be transferred to another doctor in the office.

No action was taken on the visual complaints till March of 1964 which was one year after she could no longer identify people she saw on the street. At that time, Dr. Lynch did discontinue the chloroquine. Fourteen days later Dr. Lynch on the phone told her he was releasing her to her general physician and did not want to see her again. Two years later in 1966 the plaintiff went to Dr. Cora Ruhr, an optometrist, and asked for glasses. Dr. Ruhr told her when the glasses did not solve her problem that her difficulties were caused by chloroquine or something else of that nature. After being told this by the optometrist, the plaintiff went to an ophthalmologist who saw her in
October and November of 1966 and who diagnosed her condition as retinopathy. He told her to
discontinue the chloroquine and he also called Dr. Lynch and told him not to prescribe it anymore.

The case was actually decided on legal technicalities relating to the specific working of the
Minnesota statute of limitations which is not relevant to this paper. This case is a good example of
an optometrist who did the right thing, but it appears to also be an example of how a medical center
can find itself juggling patients between doctors when it is trying to see too many patients per day
with the result that none of the doctors think about the repeated serious side effect complaints of the
drug treatments -- in this instance, over a ten-year period.

An interesting side note is that in the case of **Sterling Drug, Inc. v. Yarrow** 408 F.2d 978 (C.A.
8, 1969) the U.S. Court of Appeals held that the manufacturer of Aralen was liable for a permanent
eye condition sustained by a lady as a result of using Aralen (chloroquine) because the drug
company had failed to warn the public, the lady involved in this case, her physician and the retail
drug stores in general about the potential danger or permanent injury to vision caused by this drug,
all in violation of the Food and Drug Act. The warnings in this case should have been given to this
particular patient between January of 1958 and October of 1964, although it could have been given
as early as 1951. This case occurred essentially on or after January 1958 and was not concluded
in the U.S. Court of Appeals until March 12, 1969. A lower federal court had previously held
against the drug company (see 263 F. Supp. 159). Undoubtedly, this case resulted in the two pages
of ocular effect warnings in the revised packing slip referred to in **Johnson v. Winthrop Labs**
above.

The last case to be discussed in this section involves **Collins v. A.O.A.** 639 F.2d 636 (C.A. 7,
1982). The AOA had run a specific set of advertisements stating that optometrists as a group were
qualified to detect eye diseases, specifically glaucoma. In January 1977 the plaintiff began
experiencing vision difficulties. He went to see four different optometrists between January and
October of 1977 and in December of 1977 he went to Dr. Washington, an ophthalmologist. After
examining him, the ophthalmologist determined that he had an advanced case of glaucoma and was
losing his vision. In May of 1979 he sued three of the four optometrists and the AOA. His ground
for suit against the AOA was that AOA’s advertising concerning the qualifications of optometrists to
detect eye diseases and specifically glaucoma, was negligent and the statements therein were false.
He quickly settled with the three optometrists for unspecified amounts (probably very minimal).
In the Federal District Court, Judge Holder granted summary judgment in favor of the AOA without a
trial.

The plaintiff appealed to the U.S. Court of Appeals saying, in effect, that he had read the
advertisements of the AOA with respect to detecting glaucoma and other diseases and from them
concluded that optometrists were sufficiently well-qualified to take care of all his vision needs.
One AOA ad did specifically state "that optometrists were educated and qualified to detect glaucoma
and give the best vision care possible." Collins v. A.O.A. 639 F.2d 636 at 638 The plaintiff
claimed that other AOA ads made statements to the effect that optometrists were capable of giving
preventive care when, in fact, they were not so qualified in the plaintiff’s opinion. From all this,
he concluded that the AOA caused the progression of his condition from a non-impairing and
controllable glaucoma to that of a disabling, irreversible near blindness.

The trial court granted summary judgment in favor of the AOA which is the subject of review
by the Appellate Court. The trial court had found:

1. "as a matter of law that AOA’s representations were neither false nor misleading", based
   upon both advertisements and 73 brochures given out by the AOA.
2. "that AOA’s representations are not misleading because the Optometry Code of Indiana
   establishes as a matter of law that optometrists are educated, licensed and qualified to
detect (but not treat) signs of eye diseases such as glaucoma." "
3. "in the case before us, the undisputed facts demonstrate that the representations made
   by the AOA, regardless of their accuracy, were not the proximate cause of the plaintiff’s
   injuries." The court then defined proximate cause under Indiana law as a cause which in
   a natural and continuous sequence, unbroken by any efficient intervening cause, produces
   the result, and without which the result would not have occurred.
4. The court even went so far as to look at the case as a suit for misrepresentation, instead
   of a suit for personal injuries (even though it had found no misrepresentation by the AOA
   finding (2) above) and decided that the AOA owed no duty to the plaintiff specifically with
   respect to his eye care. The Court of Appeals affirmed this decision in favor of the AOA.
Collins v. A.O.A. 639 F.2d 636 at 639

Documentation -- The optometrist’s best defense in a litigation case is complete, thorough
documentation. Time spent in proper recordkeeping (before any claim is made) can determine the
difference between a successful or unsuccessful defense in court. Therefore, documentation is
among the optometrist's best routes for "preventive medicine". The following discussion includes points to consider and suggestions that the practitioner may utilize.

Complete documentation of exam results is vital. Findings not recorded are presumed to have not been performed in the first place. Tonometry is a very important test to administer on all patients, not just those over 40 years of age, as demonstrated by the Helling case. The fact that those below 40 seldom have glaucoma does not protect the practitioner from liability. Those patients with a measurement of 19-22 mmHg should be informed that they are on the upper limit of the normal range and need to have their ocular pressure checked regularly. Most patients fail to realize the importance of high IOP, and the possibility of glaucoma, its vision-threatening effects and the fact that in most instances it is painless and symptomless all need to be discussed with the patient. This discussion should be documented, along with the pressures and any comments or questions the patient makes.

Ocular health is another area that needs to be carefully documented. Notations such as "within normal limits (WNL)" and "no apparent pathology (NAP)" indicate that the health was assessed, however, if this is written in all the patients' records, the finding may be questioned in court. Regarding ophthalmoscopy, the C/D ratio, A/V ratio, Elschnig classification, macular integrity and any abnormalities or pathological conditions should be recorded to help establish that a thorough examination was performed on the particular patient. Similarly, biomicroscopy findings should include anterior chamber depth, media clarity, presence of any opacities or scars, any pathology evident and a description of any abnormality of the eye and adnexa. Normal benign abnormalities should not be disregarded and omitted from the record since the notation can help establish that the optometrist made thorough observations and maintained detailed, accurate records. A drawing or photograph of any unusual findings during ophthalmoscopy or biomicroscopy should be included in the record for documentation and monitoring purposes. They may prove to be invaluable in court. Forms with a general fundus or eye and adnexa outline provide a quick and efficient way to pictorially document findings.

Probably the best means of recording visual fields is a graphical display indicating
constrictions, scotomas, reduced thresholds and other defects. The date, lenses utilized and a written note stating the defects considered significant are necessary. Inclusion of what was discussed with the patient and the patient's responses are highly advisable. If any defects appear that cannot be explained by the patient's age, known pathological condition or medications, further testing is indicated to ascertain the underlying cause. Entries like "WNL" or "no apparent defects" may or may not be considered sufficient in court and the above method is far superior and provides concrete evidence that fields were taken properly and analyzed appropriately. Confrontation fields should be done on everyone, but of course, are not sufficient for glaucoma patients and in any cases of suspected field defects.

Dilated and cycloplegic exams require special documentation. Before any pharmaceutical agent is instilled, document all relevant findings (even if no allergic responses or adverse reactions were indicated) so it is apparent that all appropriate questions were asked of the patient. In addition, the IOP and anterior chamber depth need to be performed and recorded prior to administration. Failure to do these things with subsequent adverse consequences will be deemed as negligence. The patient should be informed of the reason for the procedure and the pharmaceutical, as well as the possible side effects they may experience. Patient comments should be written down. An entry must be made listing the name of the drug, concentration, amount, time and date of instillation. Any drops added later must also be entered. IOP measurement and recording after completion of the procedure is recommended.

Observations during binocular or monocular indirect ophthalmoscopy need to be recorded and preferrably illustrated on a fundus drawing. Certainly any pathological condition should be documented, including size, description, location and severity. Benign changes or those that are not currently a problem should also be noted. The latter include bear tracks, nevi, drusen, optic disc or vessel anomalies, peripheral lattice degeneration, pigmentary changes, cilioretinal arteries and any benign deviations. These should be documented to permit monitoring and immediate recognition should they alter in their form or revert to non-benign conditions. If nothing abnormal is found, the notation should indicate that the various structures were evaluated and found normal. Do not
leave the record blank because that implies that the procedure may never have actually been performed. Any pathology or condition requiring periodic monitoring should be discussed with the patient and the relative risks and prognosis should be included.

Similar advice is relevant for gonioscopy. The visible structures should be noted, as well as the grading of the angle in the full circumference. A plateau iris or angle recessions need to be recorded. The patient should be informed if there is a risk of angle closure, glaucoma or if pupillary dilation may pose a substantial risk. Document the discussion and any significant comments made by the patient.

In general, documentation must be detailed and complete. Try to avoid entries that merely read "WNL" or "NAP" or general statements that the risks were discussed with the patient. In a court case other patient records may well be subpoenaed and if the same entry is found in all the records, a question as to the validity of the finding will be raised. More descriptive, individualized findings will promote believability and bolster the defense. Furthermore, any test results not documented will be viewed as not having been performed. Therefore, include notation on all procedures administered.

In regard to corrections or changes made in the patient's record, make sure it is done in a fashion that will not be construed as falsifying or altering the record. Never erase or scratch out the initial entry so that it can no longer be read. Probably the best method is to draw a line through it, add the corrected entry, date and sign it and also state the reason for the correction. Needless to say, if a claim is made by a patient, any changes made in the file will be considered as an alteration of the record.

Computerized recordkeeping is a new trend in the optometric practice. Although it can substantially add to the ease of filing and retrieving patient information, it does pose an interesting legal issue. Information stored in a computer can be easily altered and the admissability of a computerized patient record as evidence in court is extremely doubtful. One way around this obstacle is to keep a hard copy on hand (for each patient) that the optometrist dates and signs. This means having duplicate records, one computerized and one in a patient's folder, and continued need
Failure to Diagnose and Refer -- The largest category of the malpractice claims involves the failure to diagnose or failure to refer in a timely fashion. If an ocular pathology goes undiagnosed or is misdiagnosed, and particularly if the condition causes vision loss, liability due to negligence will probably ensue. Even if the pathology is correctly identified, but the condition mandates a timely referral for the proper treatment, testing or precautions and no referral is made, then negligence has occurred. Another way to incur liability is a failure to disclose to a patient with a given condition any substantial risk factors that he has which can lead to a higher probability of adverse consequences than an individual without those risk factors. All in all, this is a large area for claims made in the past and will probably continue to be in the future. The following is a brief discussion of some common conditions that if undiagnosed or not treated in the appropriate fashion will result in liability.

Glaucoma -- Glaucoma has appeared in a number of cases in the "law books" and therefore, it necessitates special attention. First of all, do not fail to perform tonometry, even if the patient is young and unlikely to have glaucoma. In the rare event that the person does have the condition and is subsequently diagnosed after some damage has occurred in the meantime, no successful defense will be possible. If glaucoma is suspected, make sure that several IOP measurements are made, the optic nerve head is extensively evaluated including with a 90D or Hruby lens, visual fields are plotted (preferably threshold), gonioscopy is performed to view the angle structures and a careful case history is documented, including risk factors, family and personal ocular history and a listing of any medications that the patient is taking. Based on all this information, make a correct decision as to whether the patient should be monitored or treated. In either case, ensure that an adequate follow-up schedule is instituted and that the patient complies. If a patient fails to appear for a follow-up, phone the patient (preferably twice) and document the matter and the communication on both sides in the record. Furthermore, explain to the patient the nature of the disease, whether he is an ocular hypertensive or in fact has glaucoma, the reason for the
follow-ups, the adverse consequences if he fails to comply and in the event of treatment, the potential side effects, the proper way to instill the drops and once again, the need for follow-ups. Glaucoma is frequently painless and symptomless and patients often fail to understand that a condition that has no visible manifestations to them can have such dire consequences if not attended to in the appropriate manner. Thus, it is essential to impress upon the patient the above delineated points and make the proper documentation in the record.

There are a number of illustrative cases involving failure to diagnose glaucoma, the most famous of which is, of course, *Hellina v. Carev.* (see Appendix B). Another case is of *Saunders v. Lischkoff* 137 Fla 826, 188 So. 815 (1939) where an EENT specialist had diagnosed plastic iritis and prescribed atropine. The result was badly deteriorated vision and extreme pain and the patient had asked the doctor to make a house call because she was in so much pain, but he had refused. She went to another eye specialist who found that she had glaucoma. The first doctor was found to be negligent based on the failure to follow-up.

In *Gates v. Jensen* 92 W.2d 246, 595 P.2d 919 (1979) the plaintiff was a 54-year-old myopic woman who came into an ophthalmologist’s office. Her IOP was 24 and she complained of gaps in her vision, fogging and blurring. The ophthalmologist did not perform a dilated exam or fields and he told her when she had inquired, that her IOP was "ok". This ophthalmologist saw her 12 times in the next two years and during all this time, he made no further tests. On the twelfth visit she had very severe vision loss and glaucoma. The Washington Supreme Court affirmed a judgment in her favor holding that the doctor had violated the informed consent rules because she had a right to know any abnormalities that he had discovered (i.e. IOP of 24) nor did he tell her of the availability of fields and dilation to help with the diagnosis of glaucoma. It also held that the doctor’s treatment did not meet the professional standard of care because he had failed to do fields, dilation or even repeat tonometry over the 12 visits in the two-year time period.

A further case involves *Holmes v. Iwasa & Berkley Bio-Engineering Int. et al* 104 Idaho 179, 657 P.2d 476 (Su. Ct. Idaho, 1983). Dr. Iwasa, an optometrist, saw the plaintiff twice. On the first visit he had examined the plaintiff, prescribed glasses for her and had failed to diagnose
glaucoma. On the second visit he fitted the glasses with no re-examination. However, on this visit the plaintiff complained of headaches and sensitivity to bright lights. It should be noted that 15 months before the first visit, the plaintiff had a previous exam where she had complained of light sensitivity and headaches. This is strong evidence that whatever the condition was, it had existed for at least 15 months. Later, an exam was made by an ophthalmologist and she was found to have glaucoma with severe vision loss. Dr. Iwasa really was lucky. The two-year Idaho statute of limitations ran after the first visit and before the second one, and therefore, any injury resulting from his failure to diagnose during the first visit could not be a basis of a lawsuit. The interesting question is that the second visit which was within the statute of limitations period was only fitting of glasses. There was no exam during the second visit, however, if he had been under a legal duty to re-examine when he fitted the glasses, he could have been sued for all of her injuries. In reviewing the case, the Idaho Supreme Court held that he did not have a legal duty to re-examine and therefore, his negligence (that undoubtedly resulted in glaucomatous damage) during the first visit was barred by the statute of limitations and during the second visit he was not legally required to re-examine. Thus, the patient could not sue the person, who in fact had caused her injuries. The judgment went in favor of the optometrist. The decision for this case is included in Appendix C.

In *Harris v. Groth*, 99 W.2d 438, 663 P.2d 113 (Su. Ct. Wash., 1983), the plaintiff had an intermittent history of recurring iritis and saw the first ophthalmologist who made a diagnosis of iritis. He prescribed systemic and topical steroids and atropine drops. Two months after her last visit to this ophthalmologist, she saw flashing lights, wavy lines and within weeks experienced a sensation of ocular pressure. She returned to the ophthalmologist and he increased the dosage of the steroids, but her symptoms persisted. She returned again and was seen by a second ophthalmologist who diagnosed acute glaucoma. He performed emergency surgery and there was a further hospitalization, but vision continued to deteriorate. The plaintiff sued the first ophthalmologist and the pharmacist. The atropine prescription had erroneously been filled with Isopto-carpine (pilocarpine). The court held that the pharmacist was guilty of negligence as a matter of law.

The case went to trial against the first ophthalmologist only. When the plaintiff’s problems
became serious, the ophthalmologist had delivered an intensive amount of treatment over a short period of time in order to save her vision. Although he had never suspected that the prescription had been improperly filled and one of his partners made the actual diagnosis of an acute glaucoma attack, the jury found that he was not negligent and this decision was affirmed by the Washington Supreme Court on appeal.

Finally, *McMahon v. Glixman* 393 N.E.2d 875 (Su. Ct. Mass., 1979) involves a case that is only a preliminary hearing which under Massachusetts procedure determines whether or not there is sufficient evidence to justify the time and expense of a full trial. The court found that there was enough evidence to go to trial. The unusual facet of this case is that the defendant is an optometrist and the expert witness for the plaintiff who testified against him as to the applicable professional standard of care, was also an optometrist. Unfortunately, most defendant optometrists are opposed by an ophthalmologist as an expert witness. The plaintiff's evidence in this case showed that the defendant had examined him and prescribed glasses many times, the last of which was made in 1974. In March and June of 1975 he returned twice complaining of blurred vision. On each occasion the defendant dilated his eyes and assured him there was no problem. On October 31, 1977, the plaintiff was examined by an ophthalmologist due to complaints of blur in the left eye, frontal headaches, seeing halos around street lights and watering of the eyes. The ophthalmologist diagnosed his condition as bilateral glaucoma.

The glaucoma was far advanced in the left eye and its optic disc was irreversibly damaged. The right eye was not as far advanced, but did have glaucoma. In January 1978 the ophthalmologist operated on the left eye. The plaintiff contended that an experienced, trained optometrist could have seen the presence of glaucoma as early as June 1975. The ophthalmic surgeon who operated on the left eye said in his written report that in his opinion, "precious time had been lost by the optometrist not recognizing or having an index of suspicion for the plaintiff's symptoms which are classical for glaucoma. In addition, he (the plaintiff) was lulled into a sense of security by having diagnostic drops instilled and by having been given unwarranted reassurance. Ophthalmological consultation should have been sought in any event immediately." *McMahon v. Glixman* 393 N.E.2d
In addition to this report by the ophthalmologist, the plaintiff called as an expert witness Dr. Ceavey who was an optometrist. He reviewed the hospital records, the written report of the ophthalmologist and concluded in court that "the optometrist is morally and ethically obligated to refer a patient with suspicious symptoms or clinical data to an ophthalmologist if glaucoma is suspected. In my opinion, Dr. Glixman did not conform to the standards of his profession. If glaucoma was suspected by history, symptoms or clinical data and the patient was not informed and referred to the ophthalmologist of his choice," then there was negligence. In addition to these defects in the treatment rendered and reviewed by this optometrist (expert witness), the defendant had by dilating implied that he had made a thorough examination when he had not and also orally assured the patient that nothing was wrong on several occasions. The Massachusetts Court sent this case out for full trial.

**Retinal Detachment** -- The next substantial area for potential litigation is the failure to diagnose a retinal detachment or a delay in the diagnosis. Whenever a patient comes in complaining of flashing lights, light streaks, a black dot in their field of view or a curtain, veil or mist in their vision, one needs to rule out a retinal tear or retinal detachment. A thorough fundus examination is necessary with pupillary dilation and utilization of binocular indirect ophthalmoscopy, preferably with scleral depression. Check all quadrants of the fundus and examine all the way out in the periphery to the ora serrata. If a retinal tear or detachment is missed and later it is established that it must have been present due to evidence such as successive demarcation lines, then the practitioner will be deemed negligent based on failure to diagnose. In the event of one of these two conditions, refer in a timely fashion to a retinal specialist for treatment. If the cause is a posterior vitreous detachment, reassure the patient, but inform him that he has an increased risk for a retinal detachment and he should have regular eye exams. Also, inform him of the warning symptoms of a retinal detachment. Documentation should include the fact that a thorough peripheral fundus exam was performed with any problems noted, to whom the patient was referred and when (if a referral is indicated) and what was said to the patient. One important point is that a failure to dilate a patient with these symptoms will be held as negligent as
an adequate view of the peripheral fundus would not be possible. If the media is unclear and does not permit a good view, seriously consider referring the patient for ultrasonography. 27,36 As a side note, an asymptomatic patient that is highly myopic, an aphake or a pseudophake is at higher risk for a tear or detachment and should have a thorough dilated peripheral fundus exam on a regular basis. Be on the lookout for a possible retinal detachment within six months to one year after cataract surgery. 27,36 Furthermore, let these patients know that they are in a higher risk group for these conditions.

One case illustrating the importance of a timely referral of a retinal detachment, Fairchild v. Brian 354 S.2d 675 (C.A. La., 1977), was discussed earlier in this paper. Another case involves King v. Harrington 411 S.2d 912 (Ct. App. Fla., 1982) where an ophthalmologist repeatedly failed to timely diagnose and refer a retinal detachment for surgery. More details on this case are presented later in this section. Thus, it is vital that an existing detachment be diagnosed and referred for treatment immediately.

**Diabetic Retinopathy** -- Diabetic patients, of course, are at risk of developing retinopathy and need to be followed regularly. Take a careful history and find out if the patient has his blood sugar level under control. If you find that the visual acuity has significantly changed, this is probably a good indication that the blood sugar is not under control and the patient should be referred back to his internist. 38 Check pupils, motilities and IOP. With the slit lamp look for rubeosis iridis or lens opacities. Rubeosis indicates neovascularization, can cause glaucoma and necessitates referral. A dilated fundus exam is mandatory to look for signs of background retinopathy or progression towards the proliferative stage. If the background signs become too severe or encroach upon the fovea, refer to a retinal specialist. Neovascularization of the disc or elsewhere, macular edema, vitreal or pre-retinal hemorrhages or retinal breaks or detachments also need to be referred. If a significantly differing degree of diabetic retinopathy is noted between the two eyes, the optometrist should suspect a concurrent case of glaucoma or carotid artery disease in the eye with the lesser retinopathy. 38 Once again, make the appropriate documentation in the patient’s record.

A case illustrating a failure to diagnose diabetic retinopathy is that of Fallon v. Loree 136
A.D.2d 956, 525 N.Y.S.2d 93 (Supre. Ct. App. Div., 1988). Here the defendant ophthalmologist failed to use indirect ophthalmoscopy as compared to direct and did not diagnose cataracts, as well as diabetic retinopathy. Had he used indirect ophthalmoscopy, he would have been able to diagnose the retinopathy and would have attributed the vision loss to this, rather than to the cataracts. At trial the plaintiff's theory was that because the defendant did not use the best practice method available, namely indirect ophthalmoscopy, this violated the professional standard of care. The court disagreed. The case was tried and the verdict was for the defendant ophthalmologist.

The defendant had successfully argued to the lower court that 30-40% of the ophthalmologists in the community did not routinely use indirect ophthalmoscopy. This same argument was adopted by the Appellate Court and they held that as long as the doctor used one of the methods that was generally accepted by the medical community, he did not violate the professional standard of care and could not be held liable for malpractice. (Unfortunately, the subsequent cataract surgery in this case rendered the plaintiff legally blind.) In the future this may well change and it is likely that indirect ophthalmoscopy will be considered the standard of care.

**Hypertensive and Cardiovascular Changes** -- Hypertensive patients are another group needing thorough dilated fundus exams. Whenever one sees hypertensive changes in the retina, check the patient's blood pressure and let the patient know he should consult his internist concerning potential cardiovascular problems. If the person has already been diagnosed as hypertensive and extensive retinopathy is discovered with retinal and/or disc edema, hemorrhages, cotton-wool spots and/or a macular star, he should return to the internist to ensure that his blood pressure is being controlled adequately. Those with a grade III or IV retinopathy in the Keith-Wagener-Barker classification system have a poor prognosis and a short mean life expectancy. The internist should be made aware of the ocular findings so every effort can be made to control the hypertension and enhance the life expectancy.

When patients complain of amourosis fugax and cerebral symptoms of transient ischemic attacks (transient hemiplegia of the opposite side of the body, weakness, tingling or paresis of the arm, leg or hand, etc.) or have ischemic signs of the retina (including CRAO or BRAC), venous
stasis retinopathy, signs of arteriosclerosis in the retina, history of arterial occlusive problems, a retinopathy more pronounced in one eye or a significantly lowered IOP in one eye, it is advisable to suspect internal carotid artery disease. 39 Ophthalmodynamometry and listening for bruits are indicated to help with a diagnosis. However, do not perform ODM on those prone to a detachment, patients with new, fragile vascularization and possibly glaucoma. 39 Should either ODM or the presence of bruits be positive, or if you suspect ICA disease regardless, refer right away to a cardiovascular specialist. Patients with carotid insufficiency are at risk for a serious stroke. If a patient has a stroke and it is established that the optometrist should have reasonably suspected carotid insufficiency, he could well be held liable for failure to inform the patient and refer to the appropriate specialist.

The above indicates the importance of assessing the status of the retinal vasculature and therefore, indirectly obtaining an idea of the status of the cardiovascular system. If a significant compromise is noted, make sure a prompt referral is made for a medical workup, as this may potentially save the patient from considerable damage or even his life. Retinal venous and arterial occlusions can be visually debilitating, as well as necessitate a medical investigation as to the underlying cause. CRVO has a variable visual prognosis and no medical treatment (anticoagulants or steroids) can guarantee improvement or even maintenance of vision. 40 However, some attempt is still advisable and therefore, refer these patients for this treatment. Also, in the ischemic variety, referral for panretinal photocoagulation can minimize the chances of developing neovascular glaucoma. 40 In addition, a prompt referral for blood studies and a cardiovascular evaluation is mandatory. CRAOs require immediate initiation of treatment (within 1-2 hours) to try to dislodge the embolus in order to improve the visual prognosis. 41 Once again, a medical work-up to establish and manage the underlying cause is essential.

A frequent cause of sudden vision loss in the elderly patient is ischemic optic neuropathy. Correct diagnosis with prompt and proper referral can help the patient in an attempt to retain useful vision. Make sure you rule out the possibility of temporal arteritis by taking a careful history, examine and palpate the temporal arteries and refer for an erythrocyte sedimentation rate.
If the ESR is elevated, refer for a temporal artery biopsy and probably high-dose systemic steroid treatment in the attempt to improve the visual prognosis. The idiopathic variety is often associated with hypertension, arteriosclerotic changes, occlusive artery disease, diabetes and migraine and therefore, refer the patient promptly for an appropriate work-up. Failure to refer would constitute negligence.

**Macular Degeneration** -- As the reader is probably aware, this is a leading cause of new, permanent visual disability in the U.S. In 90% of the cases, the degeneration is of the "dry" variety and there is no available treatment at this time. However, the remaining 10% is of the "wet" or exudative type and prompt referral for treatment in the early stage can potentially keep the condition from deteriorating further. Therefore, look carefully for any signs of exudative degeneration (subretinal neovascularization, subretinal hemorrhages, serous detachments or disciform scars), check for any central scotomas and perform an Amsler grid test. In a "suspect" patient, instruct him on the use of an Amsler grid, send him home with one and have him call immediately if any changes are noticed. Refer patients with exudative changes, questionable ophthalmoscopic findings, metamorphopsia and decreased visual acuity right away for fluorescein angiography and possible krypton laser treatment. Failure to do so will eliminate the chance for a favorable visual prognosis and result in permanent central vision loss. Needless to say, this may well lead to a claim and probable liability.

**Tumors** -- The final area to be discussed in this section concerns tumors. If any nevus or retinal lesion appears suspicious and may possibly be malignant, refer for a consultation to be on the safe side. Any nevus should be examined closely regarding possible elevation or any changes in its appearance. A thorough exam, of course, requires a dilated fundus exam. In addition, be on the lookout for cysts in other areas of the eye, such as the iris, ciliary body and adnexa. Keep in mind that the eye is a frequent location for metastatic tumors. A thorough visual field can aid in the detection of an intracranial lesion and unilateral exophthalmus can indicate an orbital tumor. The diagnosis of a tumor can often be a difficult one, but every attempt should be pursued should you have any reason to suspect one. This can help in minimizing or perhaps eliminate an adverse
judgment should a patient be subsequently found to indeed have a tumor with resultant damage, loss of an eye or in a catastrophic case, loss of the patient’s life. Above all, proper documentation is crucial. Two cases involving a failure to diagnose a brain tumor are *Wills v. Klingebeck* and *Evers v. Buxbaum*, both of which are discussed in detail in other portions of this paper.

Throughout this discussion certain points are extremely important to keep in mind. First of all is the obvious one of making every attempt to correctly diagnose any existing ocular pathology. If any condition is found, adequately inform the patient. The law requires that you do so in layman terms so there is full communication with the patient and he fully understands the condition, the risks and any further tests or treatment that might or are necessary. Then either institute the appropriate treatment or refer to the necessary specialist in a timely fashion. The timeliness is critical, as a delay in referral can sometimes mean potential disaster. The delay can be a cause for further deterioration for which you can be liable. Of great importance, of course, is complete, thorough documentation. Failure in any of these critical areas will be likely to impose liability and little opportunity for a successful defense should a lawsuit ensue.

**Failure to Refer** -- Regarding the duty to refer, the following are several cases that illustrate the importance of an appropriate and timely referral. The case of *Tempchin v. Sampson*, 262 Md 156, 277 A.2d 67, 51 ALR.3d 1286 (1971), involves a patient-plaintiff who went to an optometrist for an exam. The optometrist noticed some pathology and told the patient she had some spots on the lens or "incipient cataracts", but that it was no real immediate problem. The plaintiff testified that she had asked him whether she should see an ophthalmologist and was told that it was not necessary because they were very early changes, indicating that a cataract will occur later on. There was an 11-day delay before she sought an ophthalmologist due to complaints of extreme vision loss. The ophthalmologist had diagnosed uveitis and testified that if he had seen the patient on the same day as the optometrist had and had begun treatment, the condition would not have progressed to the acute phase which caused the loss of vision. The state of Maryland has the community rule and the judge's decision was that the optometrist had the duty to detect diseases of the eye, but not to treat them. He had the duty to refer, which this optometrist failed to do, and
therefore, the judgment went in favor of the plaintiff. The court held that the 11-day delay was the proximate cause of the near total vision loss as a result of the misdiagnosis. Had the optometrist indicated that the patient should go ahead and see the ophthalmologist who would have initiated treatment, the judgment would have been minimal or none at all.

Another case, *Wills v. Klingenbeck* 455 S.2d 806 (Su. Ct. Ala., 1984) involves a plaintiff's complaint against an optometrist stating that he failed to inform the plaintiff of the consequences of an eye condition and failure to refer him to an ophthalmologist or neurosurgeon. It was alleged that "the defendant (doctor) negligently failed to diagnose a brain tumor in the head of the plaintiff and negligently failed to inform or properly advise the plaintiff that the papilledema is a symptom of a brain tumor." *Wills v. Klingenbeck* 455 S.2d 806 at 806 (Su. Ct. Ala., 1984) The plaintiff stated that he was told that he had papilledema, but was not told what to do about it, whereas the defendant claimed that he did not find papilledema, but that he did determine that the patient's blood pressure was very high and that he told the patient he should consult a physician about that at once. The optometrist further claimed that since the patient was already under the care of a physician and ophthalmologist, it would have been futile to refer. However, the court felt that, regardless, the optometrist had the duty to refer. The patient was later diagnosed as having a brain tumor by a neurosurgeon. The major points, as the reader can see, involve the duty to refer, as well as provide an adequate informed consent.

Not only does the optometrist have the duty to refer, but also in a timely fashion. In *King v. Harrington* 411 S.2d 912 (Ct. App. Fla., 1982), an ophthalmologist had failed to timely diagnose a retinal detachment. Two months after the patient had initially presented the doctor with a drawing of the black spot in his field of vision and described symptoms of floaters, did the doctor dilate and examine the fundus, but he only found floaters and an absence of retinal tears or detachments. At this point in time, the doctor was given yet another drawing of the field defects. Only 24 days later the patient returned with no vision at all in the right eye, yet the ophthalmologist still adhered to his original findings. It was not until 38 days after this that the doctor admitted that he found a retinal detachment and referred the patient to another ophthalmologist for surgery. This case is a
clear example of multiple periods of failure to take timely action.

A further example of a failure to timely refer is illustrated in the case of *Steele v. U.S.*, 463 F. Supp. 321 (USDC, Alaska, 1978). Here the optometrist diagnosed accommodative esotropia in a four-year-old boy for which he prescribed glasses, and he also observed a vitreous hemorrhage in one eye. The optometrist did not refer and saw the patient again approximately one month later. At this time he recorded "no good reflex" in that one eye, did not refer and prescribed different glasses. Five months later the vision in that eye was limited to light perception and at this time, the optometrist referred the child to an ophthalmologist. The boy was then examined by a number of ophthalmologists who speculated that the condition might be either a retinoblastoma or toxocara canis. The eye condition made it impossible to distinguish between these two and due to the potential danger of retinoblastoma, the eye was enucleated. The court held that the optometrist should have informed the parents of the ocular abnormality and referred the child to an ophthalmologist on the first visit. It also stated that the optometrist most definitely should have referred on the second vision when a poor reflex in the eye was noted. The court stated that if a timely referral had been made, an ophthalmologist might have concluded that an inflammatory reaction was present and probably would have diagnosed toxocara. Steroid treatment would have been initiated and possibly would have prevented further vision loss and would have saved the eye. The point made here was that a delay in diagnosis and institution of treatment allowed further damage to occur which might have otherwise been prevented. The lesson to be learned in all of these cases involves the optometrist's duty to refer in a timely fashion.

**Vision Therapy** -- In the area of vision therapy, there have been no specific litigated cases, but this does not mean that there is no possibility for one to occur. Whatever claims have been made were settled out of court or not appealed and thus have not appeared in the legal sources. Basically, there are a few precautions one should keep in mind. Any possible pathology (tumors in particular) should first be ruled out before any program of visual training is instituted. If a patient undergoes VT and during this period a pathological condition goes undiagnosed and hence untreated, causing injury to the patient, the optometrist will be liable for negligence.
pathology that is present prior or during VT must be detected and treated in the appropriate fashion.

The above could well be pertinent in a case of amplyopia. Before institution of a vision therapy program, make sure a dilated fundus exam and probably a VER are performed and any potential pathology cause is ruled out. Furthermore, be careful if patching is utilized in the program. If the eye with the better visual acuity is made to also be amblyopic, then likely liability will result.

Another area requiring caution relates to the breakdown of an adaptation. Many strabismics have adapted to their problem and are capable of functioning in some manner in their environment. If VT is provided, the adaptation is broken down, but the patient is left with intractable diplopia, the practitioner can expect liability. The type of visual behavior and the probability of a favorable prognosis need to be assessed before any therapy is pursued. The patient should also be forewarned about potential undesirable outcomes, their probability and any discomfort (such as headaches) they may experience during the program. Postsurgical strabismics may have a cyclo component and should be identified. These patients are frequently poor candidates for successful VT or may be untreatable and the patient should be so informed.

A final note regards the misdiagnosis of a visually-related learning disability. Make certain it is an accurate diagnosis or the consequence may be a subsequent claim based on the loss of educational opportunities and career options. Since a child is involved, this could well result in a substantial judgment.

A general word of advice for all visual training is to never guarantee total cures. Realistically advise the patient on the nature of his problem and the reasonable prognosis for improvement that VT may provide. Also, do mention the other alternatives for treatment, including surgery, and discuss the pros and cons of each with the patient. Failure to disclose all the alternatives can potentially involve the optometrist in a claim.

Conclusion

Now that we have extensively discussed the various legal theories applicable in professional liability, the major potential areas for a claim, a number of illustrative cases from the "law books" and general practical hints you might incorporate into your own practice, it is hoped that the word,
malpractice, no longer brings forth to mind visions of a horrible nightmare. However, the reader should resist the temptation to use this paper to "solve" a particular pending claim or case. Basically, proper documentation, exercising due care and upholding the standards of the "prudent practitioner" and above all, common sense and a genuine concern for the patient can not only help avoid claims in the first place, but also substantially bolster a defense should an eye care professional be unfortunate enough to be named in a suit. Keep in mind that typically two-thirds of all professional liability cases are won by the defendant doctor. However, do not simply rely on this fact and neglect to build a good defense until a claim is made, at which time it will be too late. Instead, start now by incorporating good judgment and practice methods into the day-to-day activities within your own office. Let's seize this opportunity and not repeat the same mistakes made by the medical profession in the past.
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APPENDICES
APPENDIX A

The following are several examples of forms, variations of which the eye care professional may wish to include in the record of contact lens patients. These were excerpted from John Classe’s articles. 12,14,44
CONTACT LENS FITTING AGREEMENT

☐ Spherical ☐ Astigmatic (Custom Toric)
☐ Gas Permeable ☐ Aphakic
☐ Extended Wear ☐ Bifocal
☐ Astigmatic (Toric) ☐ Keratoconus

I understand the total fee for my contact lens services and materials is $__________________

AT LEAST ONE-HALF THE TOTAL FEE MUST BE PAID BEFORE LENSES ARE ORDERED. FULL PAYMENT IS REQUIRED BEFORE LENSES ARE DISPENSED.

This fee includes the services and materials as circled on the Contact Lens Fee Schedule. The only additional charges that may be incurred during the six month fitting agreement period are as follows:

I. If you have to be switched to a more expensive lens in order to accomplish a successful fit, you will only be charged the lens cost difference.

II. If the refit is a special lens as listed on the Fee Schedule there will be an additional $______ for services. If this fee was included originally there will be no additional charge.

III. If you are initially placed on a cold disinfectant system and have to be switched to a thermal system, the fee for the heating unit will be $______.

IV. If a lens is lost or damaged during the fitting period, replacement cost is as circled on the Fee Schedule next to the type of lens that you are wearing.

REFUND POLICY:

In the event that the patient or doctor decides that it is necessary to discontinue wearing the lenses for any reason, the Contact Lens Service fees as circled on the Fee Schedule are not refundable. The cost of the contact lenses (circles under Contact Lens Materials) will be refunded in full. If a Thermal Unit is returned an additional $______ will be refunded.

Six months after the lenses are dispensed this agreement ends, no refunds are given and all professional services and materials will be at our usual and customary fees in effect at that time.

I fully understand and accept this agreement.

______________________ (patient signature) ____________________ (date)

Figure 1: Sample fitting agreement (Courtesy UAB School of Optometry).
Soft Contact Lens Care and Handling

Proper care is necessary for successful wear, normal lens life, and good eye health. You will be provided with products to clean, disinfect, and store your soft lenses. Use them as instructed.

Your daily lens cleaner is ____________________________
Your weekly cleaner (if prescribed) is _________________________
Your lens disinfection method is ____________________________
° Heat
° Solution
Your overnight soaking solution is ____________________________
Your rinsing solution is ________________________________
Eye drops to use when lenses are on ___________________________

NOTE: These products have been prescribed specifically for your lenses and eyes. Do not change or substitute brands unless you check with us first. Use of improper solutions may result in lens damage or eye irritation.

SPECIAL INSTRUCTIONS ____________________________

IN THE BEGINNING IT IS NORMAL IF:
1. Your lenses itch or feel funny.
2. One lens is more noticeable than the other.
3. Your vision seems fuzzier than with glasses.
4. One eye sees better than the other.
5. You have trouble handling your lenses.

REMOVE YOUR LENSES IF:
1. You develop unusual pain or redness.
2. You experience a decrease in vision that does not clear up.
3. You suspect something is wrong.

WEARING SCHEDULE

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Next appointment: ____________________________

Figure 2: Sample patient information form (Courtesy Hayes Marketing, Inc., Copyright 1983)
Extended Wear Lens Care and Handling

Proper care is necessary for successful wear, normal lens life, and good eye health. You will be provided with products to clean, disinfect and store your extended wear lenses. Use them as instructed.

Your lens cleaner is ____________________________

Your lens disinfectant is ____________________________

Your soaking solution is ____________________________

Your rinsing solution is ____________________________

Eyedrops to use before sleep and upon waking ____________________________

NOTE: These products have been prescribed specifically for your lenses and eyes. Do not change or substitute brands unless you check with us first. Use of improper solutions may result in lens damage or eye irritation.

SPECIAL INSTRUCTIONS:---------------------------------------------

Please note that although certain brands of lenses may be FDA approved for 7, 14, or even 30 days of wear, the adaptability of your eyes is the key factor in determining wearing time. Trust us to recommend a schedule suited to your individual needs. And remember, like any medical device contact lenses must be monitored on a regular basis. Professional follow-up care is the most important element in successful long term lens wear.

IN THE BEGINNING IT IS NORMAL IF:
1) Your lenses itch or feel funny.
2) One lens is more noticeable than the other.
3) Your vision seems fuzzier than with glasses.
4) One eye sees better than the other.
5) You have trouble handling your lenses.

REMOVE AND DO NOT SLEEP IN YOUR LENSES IF:
1) You develop unusual pain or redness.
2) You develop unusually cloudy or foggy vision.
3) You experience a decrease in vision that does not clear up.
4) You suspect something is wrong.

WEARING SCHEDULE

________________________________________

________________________________________

________________________________________

________________________________________

________________________________________

Date ____________________________

Clinician ____________________________

Dispensed By ____________________________

Patient ____________________________

Next appointment ____________________________

Figure 5: Instructions for extended wear lens care and handling (Courtesy Hayes Marketing, Inc., Copyright 1984).
Follow-Up Care Agreement
For Patients Wearing
Extended Wear (Overnight)
Contact Lenses

With extended-wear contact lenses come additional care requirements. You must adhere to the recommended lens care procedures and you must return to this office for periodic progress evaluations.

We require the following progress evaluation schedule:

- After 24 hours of extended wear
- After 3 days of extended wear
- After 1 week of extended wear
- After one month of extended wear
- After each 6 month period of extended wear

It is impossible to determine, in advance, whether you will become a successful user of extended-wear contact lenses. Certain personal, physiological, and environmental factors may adversely affect the success of extended-wear contact lenses and may necessitate a change in the recommended wearing schedule or termination of lens wear. These factors include:

- Poor lens hygiene
- Inability or unwillingness to return for follow-up visits
- History of allergic reactions
- Manual dexterity problems which would prevent periodic lens removal and cleaning
- Severe emotional stress
- Use of certain medications

If you experience discomfort, redness, extreme sensitivity to light, or blurry vision, remove your contact lenses at once and call this office. Do not ignore these symptoms.

If a lens accumulates deposits such as protein, calcium, nicotine, etc., which cannot be removed, that lens must be replaced. In some instances a lens may become displaced from the eye and get lost or damaged, requiring a replacement.

Your cooperation is vital to your success with extended wear contact lenses.

I understand the importance of adhering to the proper lens care procedures, of periodic follow-up examinations and agree to keep scheduled appointments and follow the doctor's advice for continued safe extended-wear.

__________________________  __________________________
(patient's signature)  (date)

Figure 1: Sample agreement form for extended wear patients. (This form is copyrighted and is available only from Barnes-Hind, Inc.)
Extended Wear Lens Care and Handling

Lens Care Instructions

Proper care is necessary for successful wear, normal lens life, and good eye health. You will be provided with products to clean, disinfect and store your extended wear lenses. Use them as instructed.

Your lens cleaner is __________________________
Your lens disinfectant is __________________________
Your soaking solution is __________________________
Your rinsing solution is __________________________
Eyedrops to use before sleep and upon waking __________________________

NOTE: These products have been prescribed specifically for your lenses and eyes. Do not change or substitute brands unless you check with us first. Use of improper solutions may result in lens damage or eye irritation.

Please note that although certain brands of lenses may be FDA approved for 7, 14, or even 30 days of wear, the adaptability of your eyes is the key factor in determining wearing time. Trust us to recommend a schedule suited to your individual needs. And remember, like any medical device, contact lenses must be monitored on a regular basis. Professional follow-up care is the most important element in successful long term lens wear.

In the beginning it is normal if:

1) Your eyes itch or feel funny.
2) One lens is more noticeable than the other.
3) Your vision seems fuzzier than with glasses.
4) One eye sees better than the other.
5) You have trouble handling your lenses.

Remove and do not sleep in your lenses if:

1) You develop unusual pain or redness.
2) You develop unusually foggy or cloudy vision.
3) You experience a decrease in vision that does not clear up.
4) You suspect something is wrong.

Wearing Schedule

X

Patient’s Signature

Dispensed By

Date

Figure 2: Sample written instructions to extended wear patients for proper lens care and handling. (This form is copyrighted and is available only from Hayes Marketing, Inc., Vicksburg, MS.)
CONTACT LENS SERVICE AGREEMENT

Our policy is to examine ____ contact lens wearers at least twice a year, in order to evaluate their eyes and the ____ lenses themselves. At all examinations we review care and cleaning of the lenses, evaluate the patient's progress in general, and try to prevent problems from occurring. We want our patients to have the freedom to call upon us whenever they experience difficulty or have questions, and to replace contact lenses or get additional ones at the lowest cost possible.

For these reasons we utilize a ____ Contact Lens Service Agreement, which includes the following:

1 -- Semi-annual examination of eyes and ____ contact lenses.
2 -- Periodic checkup of eyes and ____ contact lenses whenever difficulty is encountered.
3 -- Purchase of ____ contact lenses at laboratory costs plus a minimum handling charge.
4 -- Cleaning of ____ contact lenses when needed.
5 -- Minimum charges for the exchange of ____ contact lenses.

Although we cannot extend the ____ Contact Lens Service Agreement to patients whom we have not examined, we are happy to examine, establish, and maintain a patient record for persons now wearing soft contact lenses, and who wish to use our services.

Our ____ Contact Lens Service Agreement covers a period of one year. Renewal may be accomplished annually provided we make an examination of the patient during the twelve month period. The ____ Contact Lens Service Agreement may be renewed anytime within thirty days of expiration. It may be reinstated thereafter if we have examined the patient within the preceding twelve months, for a $ ____ fee, or upon completion of a current examination of eyes and lenses.

We agree to provide __________________________ with the following services:

1 -- Perform two contact lens examination per year.
2 -- No charge for office calls during the year.
3 -- Purchase of additional lenses at $ ____ per lens.
4 -- Exchange of lenses for any reason at $ ____ per lens.
5 -- Cleaning of lenses as required at no charge.

I have read and understood the above agreement. I agree to pay $ ____ as consideration for the services enumerated above.

(Patient's signature)  (Witness)

Figure 3: Sample prepaid service agreement (Courtesy Drs. McEachern, Cannon, and McClay).

FOLLOW-UP CARE AGREEMENT FOR EXTENDED WEAR CONTACT LENSES

With extended-wear contact lenses come additional care requirements. You must adhere to the recommended lens care procedures and you must return to this office for periodic progress evaluations.

We require the following progress evaluation schedule:

- After 24 hours of extended wear
- After each month of extended wear for the first 6 months
- After each 6 month period of extended wear

It is impossible to determine, in advance, whether you will become a successful user of extended-wear contact lenses. Certain personal, physiological, and environmental factors may adversely affect the success of extended-wear contact lenses and may necessitate a change in the recommended wearing schedule or termination of lens wear. These factors include:

- Poor lens hygiene
- Inability or unwillingness to return for follow-up visits
- History of allergic reactions
- Use of certain medications

If you experience discomfort, redness, extreme sensitivity to light, or blurry vision, remove your contact lenses at once and call this office. Do not ignore these symptoms.

If a lens accumulates deposits such as protein, calcium, nicotine, etc., which cannot be removed, that lens must be replaced. In rare instances a lens may dislodge from the eye and be lost or damaged, requiring a replacement. Lens life is unpredictable; frequent lens replacements should be expected.

Your cooperation is vital to your success with extended wear contact lenses.

I understand the importance of periodic follow-up examinations and agree to keep scheduled appointments and follow the doctor's advice for continued safe extended wear. Noncompliance will be grounds for termination of extended-wear program.

(Patient's signature)  (Date)

Figure 4: Sample extended wear fitting agreement (Courtesy UAB School of Optometry).
With extended-wear contact lenses come special responsibilities and requirements. You must adhere to the recommended lens wear and care procedures and you must return to the Clinic for periodic progress evaluations.

We require the following Progress Evaluation Schedule:

- 24 hours after beginning overnight wear of the contact lenses
- 3 days after beginning extended wear of the contact lenses
- 1 week after beginning extended wear of the contact lenses
- 2 weeks after beginning extended wear of the contact lenses
- 4 weeks after beginning extended wear of the contact lenses
- Each 13 week period after beginning extended wear of the contact lenses

It is impossible to determine in advance whether a patient will have a successful response to extended-wear contact lenses. Certain personal, physiological, and environmental factors may adversely affect the success of extended-wear contact lenses and may necessitate a change in the recommended wearing schedule or termination of lens wear. These factors include, but are not limited to:

- Poor lens hygiene
- Inability or unwillingness to return for follow-up visits
- Manual dexterity problems which would prevent periodic lens removal and cleaning
- Severe emotional stress
- Use of certain medications
- Inability or unwillingness to follow instructions

As with any other drug or device, the use of extended-wear contact lenses is not without risk. A small, but significant, percentage of individuals wearing extended wear lenses develop potentially serious complications which can lead to permanent eye damage and vision loss.

**IF YOU HAVE ANY OF THE FOLLOWING:**

- Eye pain or Irritation
- Watering of or discharge from the eye
- Redness of the eye
- Cloudy or decreased vision, or
- Sensitivity to light,

**THEN,**

REMOVE YOUR LENSES AND CALL THE CLINIC IMMEDIATELY. WE WILL ARRANGE TO HAVE YOU EXAMINED AS NEEDED. DO NOT RESUME LENS WEAR UNTIL ADVISED TO DO SO BY US. IF YOU ARE UNABLE TO REACH THE CLINIC, CALL AN EYE DOCTOR.

Figure 1: Informed consent agreement for disposable lenses.
You have been fitted with the following type of extended wear contact lenses:

<table>
<thead>
<tr>
<th>TYPE</th>
<th>MANUFACTURER / BRAND</th>
</tr>
</thead>
<tbody>
<tr>
<td>_ soft contact lenses</td>
<td>______________________</td>
</tr>
<tr>
<td>_ gas permeable contact lenses</td>
<td>______________________</td>
</tr>
<tr>
<td>_ disposable soft contact lenses</td>
<td>______________________</td>
</tr>
</tbody>
</table>

Each type of extended wear contact lens requires somewhat different methods of care and handling.

LENS CARE INSTRUCTIONS

Proper care is necessary for successful wear, proper vision, good eye health and normal lens life. You have been instructed in the proper methods of lens care and handling. You have been provided with products to clean, disinfect and store your extended wear lenses. Use them as instructed. Please refer to your instruction sheet entitled: CONTACT LENS CARE AND HANDLING FORM for your prescribed lens care products. The products which have been prescribed are specifically for your eyes and lenses. Do not change or substitute brands unless you check with us first. Use of improper solutions may result in eye irritation or lens damage.

Please note that certain brands of lenses may be approved by the FDA for 7, 14, or even 30 days of wear. Patients should not wear extended-wear lenses for more than 7 consecutive days. Lenses must be left off overnight and in the prescribed disinfection system before lens wear may be resumed. Please refer to your instruction sheet entitled: CONTACT LENS CARE AND HANDLING FORM for your prescribed lens wearing schedule.

PROGRESS EVALUATIONS

Like any medical device, contact lenses must be monitored on a regular basis. Professional follow-up care is the most important element in successful long-term lens wear. Regular examination by an eye doctor is necessary to evaluate your eye's response to extended wear.

It is important for the health of your eyes that you carefully follow the schedule recommended by the Clinic for wearing, cleaning, and disinfecting your lenses. If a lens accumulates deposits such as protein, calcium, nicotine, etc., which cannot be removed, that lens must be replaced. In some instances a lens may become displaced from the eye and become lost or damaged, requiring a lens replacement.

DISPOSABLE EXTENDED-WEAR CONTACT LENSES

If you are wearing disposable contact lenses, you must remove your lenses and discard them according to the schedule prescribed for you. Disposable lenses should not be used after removal from the eye. Only new lenses should be worn during the next wearing period. Patients should not wear disposable extended-wear lenses for more than 7 consecutive days. We are advising you to follow the wearing schedule:

Remove lenses after _____________ days of wear.

Keep the eyes free of any lenses for _____________ hours.

If no problems are encountered, repeat the above schedule for _____________ weeks, after which time you will return for a progress evaluation and a new supply of lenses will be dispensed.

Figure 1: Continued.
PATIENT RESPONSIBILITY

I understand that my cooperation and compliance is vital to my success with extended-wear contact lenses.

I have been instructed in the proper methods of lens care and handling. I understand the importance of adhering to proper lens care procedures and the need for periodic follow-up examinations. I agree to follow the recommended wearing schedule and to keep scheduled appointments. I agree to follow the Clinic's advice for safe extended-wear as indicated on this form and in my clinic record. I will notify the Clinic immediately if any eye or vision problems occur. If I am unable to reach the Clinic, I will call an eye doctor immediately.

I understand that extended-wear contact lenses have many benefits but, as with any other drug or device, they are not without possible risks. A small percentage of wearers develop serious complications including corneal ulcers which can lead to permanent eye damage and vision loss. I agree to follow the advice and instructions given to me by the Clinic. I will remove my lenses and seek care immediately if I experience any eye pain, redness, or decrease in vision.

I have been told the nature, purpose and benefits of extended-wear contact lenses. I have also been told the possible risks, consequences, and side effects of extended-wear contact lenses, which are greater than those of daily-wear contact lenses. I know there are feasible alternatives, including daily-wear contact lenses and spectacles. I understand that I may not be able to successfully wear extended-wear contact lenses. I will be able to ask any questions that I have concerning the Clinic's policies and contact lenses prior to the ordering of lenses.

By my signature, I acknowledge that I have read, understood, and received a copy of the INFORMATION ON EXTENDED WEAR CONTACT LENSES, the CARE AND HANDLING FORM and the UABSO CONTACT LENS FITTING AGREEMENT. I understand the Clinic's current policies, fees and refund schedule.

Signed ________________________________
Patient

Signed ________________________________
Parent or Guardian if patient is a minor

Contact Lenses Dispensed by ________________________________

Date ________________________________

Figure 1: Continued.
APPENDIX B

The case of *Helling v. Carey* is an often cited example of failing to perform tonometry and allowing a glaucomatous condition to go undiagnosed. A copy of the decision made by the Washington Supreme Court in this case follows and is included for the reader's interest.
circumstances, collective bargaining is not always futile and is frequently successful. As the saying goes, one can lead a horse to water but cannot make it drink; but it is better to lead it as far as it will peaceably go than not to make the effort. Thus, the statute (RCW 49.32.020) should be interpreted to mean that, while the courts cannot mandate the achievement of a final agreement nor dictate its terms, they can, however, under their equity powers, apply the statute by ordering at least that the parties bargain collectively in good faith, for a reasonable time, and until it is reasonably clear that further negotiations must necessarily be futile. That is all that plaintiffs ask for here and that, I think, they are entitled to receive under RCW 49.32.020.

[No. 42773. En Banc. March 14, 1974.]

Morrison P. Helling et al., Petitioners, v. Thomas F. Carey et al., Respondents.

[1] Physicians and Surgeons—Malpractice—Standard of Care—Standard of Profession—Insufficiency—Effect. A physician may be guilty of negligence, even though he adheres to that standard of care and skill expected of the average practitioner in the class to which he belongs, if reasonable prudence requires a higher degree of care. In determining whether reasonable prudence requires care not ordinarily exercised by the average practitioner, the court will consider the complexity and cost of the additional care, its risks if any, its reliability, and the consequences of failure to exercise the care.

[See Ann. 21 A.L.R.2d 953; 61 Am. Jur. 2d, Physicians, Surgeons, and Other Healers §§ 110, 119.]

[2] Physicians and Surgeons—Malpractice—Standard of Care—Standard of Profession—Glaucoma. A skilled and qualified ophthalmologist is negligent in not routinely giving a test for glaucoma to all persons suffering any eye discomfort, notwithstanding that the standard of the profession does not require the routine giving of such test to persons under the age of 40, since although glaucoma is found in only one out of every 2,000 persons under the age of 40, the test is simple, inexpensive, and harmless, and the consequence of the disease going undetected is irreversible blindness.

Utter, Finley, and Hamilton, JJ., concur by separate opinion.


The Court of Appeals affirmed, by unpublished opinion, a judgment of the Superior Court for King County, No. 714089, Howard J. Thompson, J., entered December 18, 1970. The appellants (plaintiffs) petitioned the Supreme Court for review.

Action for medical malpractice. The plaintiffs appealed to the Court of Appeals from a judgment entered on a verdict in favor of the defendants.

Olwell, Boyle & Hattrup and Lee Olwell, for petitioners.

Williams, Lanza, Kastner & Gibbs and Henry E. Kastner, for respondents.

Hunter, J.—This case arises from a malpractice action instituted by the plaintiff (petitioner), Barbara Helling.

The plaintiff suffers from primary open angle glaucoma. Primary open angle glaucoma is essentially a condition of the eye in which there is an interference in the ease with which the nourishing fluids can flow out of the eye. Such a condition results in pressure gradually rising above the normal level to such an extent that damage is produced to the optic nerve and its fibers with resultant loss in vision. The first loss usually occurs in the periphery of the field of vision. The disease usually has few symptoms and, in the absence of a pressure test, is often undetected until the damage has become extensive and irreversible.

The defendants (respondents), Dr. Thomas F. Carey and Dr. Robert C. Laughlin, are partners who practice the medical specialty of ophthalmology. Ophthalmology involves the diagnosis and treatment of defects and diseases of the eye.

The plaintiff first consulted the defendants for myopia, nearsightedness, in 1959. At that time she was fitted with contact lenses. She next consulted the defendants in Sep-
tember 1963, concerning irritation caused by the contact lenses. Additional consultations occurred in October 1963; February 1967; September 1967; October 1967; May 1968; July 1968; August 1968; September 1968; and October 1968. Until the October 1968 consultation, the defendants considered the plaintiff’s visual problems to be related solely to complications associated with her contact lenses. On that occasion, the defendant, Dr. Carey, tested the plaintiff’s eye pressure and field of vision for the first time. This test indicated that the plaintiff had glaucoma. The plaintiff, who was then 32 years of age, had essentially lost her peripheral vision and her central vision was reduced to approximately 5 degrees vertical by 10 degrees horizontal.

Thereafter, in August of 1969, after consulting other physicians, the plaintiff filed a complaint against the defendants alleging, among other things, that she sustained severe and permanent damage to her eyes as a proximate result of the defendants’ negligence. During trial, the testimony of the medical experts for both the plaintiff and the defendants established that the standards of the profession for that specialty in the same or similar circumstances do not require routine pressure tests for glaucoma upon patients under 40 years of age. The reason the pressure test for glaucoma is not given as a regular practice to patients under the age of 40 is that the disease rarely occurs in this age group. Testimony indicated, however, that the standards of the profession do require pressure tests if the patient’s complaints and symptoms reveal to the physician that glaucoma should be suspected.

The trial court entered judgment for the defendants following a defense verdict. The plaintiff thereupon appealed to the Court of Appeals, which affirmed the judgment of the trial court. Helling v. Carey, 8 Wn. App. 1005 (1973). The plaintiff then petitioned this court for review, which we granted.

In her petition for review, the plaintiff’s primary contention is that under the facts of this case the trial judge erred in giving certain instructions to the jury and refusing her proposed instructions defining the standard of care which the law imposes upon an ophthalmologist. As a result, the plaintiff contends, in effect, that she was unable to argue her theory of the case to the jury that the standard of care for the specialty of ophthalmology was inadequate to protect the plaintiff from the incidence of glaucoma, and that the defendants, by reason of their special ability, knowledge and information, were negligent in failing to give the pressure test to the plaintiff at an earlier point in time which, if given, would have detected her condition and enabled the defendants to have averted the resulting substantial loss in her vision.

[1, 2] We find this to be a unique case. The testimony of the medical experts is undisputed concerning the standards of the profession for the specialty of ophthalmology. It is not a question in this case of the defendants having any greater special ability, knowledge and information than other ophthalmologists which would require the defendants to comply with a higher duty of care than “that degree of care and skill which is expected of the average practitioner in the class to which he belongs, acting in the same or similar circumstances.” Pederson v. Du Meouchel, 72 Wn.2d 73, 79, 431 P.2d 973 (1967). The issue is whether the defendants’ compliance with the standard of the profession of ophthalmology, which does not require the giving of a routine pressure test to persons under 40 years of age, should insulate them from liability under the facts in this case where the plaintiff has lost a substantial amount of her vision due to the failure of the defendants to timely give the pressure test to the plaintiff.

The defendants argue that the standard of the profession, which does not require the giving of a routine pressure test to persons under the age of 40, is adequate to insulate the defendants from liability for negligence because the risk of glaucoma is so rare in this age group. The testimony of the defendant, Dr. Carey, however, is revealing as follows:

Q. Now, when was it, actually, the first time any complaint was made to you by her of any field or visual field
of reasonable prudence, whether it usually is complied with or not.

In *The T.J. Hooper*, 60 F.2d 737 (2d Cir. 1932), Justice Hand stated on page 740:

"[I]n most cases, reasonable prudence is in fact common prudence; but strictly it is never its measure; a whole calling may have unduly lagged in the adoption of new and available devices. It never may set its own tests, however persuasive be its usages. Courts must in the end say what is required; there are precautions so imperative that even their universal disregard will not excuse their omission."

(Italics ours.)

Under the facts of this case reasonable prudence required the timely giving of the pressure test to this plaintiff. The precaution of giving this test to detect the incidence of glaucoma to patients under 40 years of age is so imperative that irrespective of its disregard by the standards of the ophthalmology profession, it is the duty of the courts to say what is required to protect patients under 40 from the damaging results of glaucoma.

We therefore hold, as a matter of law, that the reasonable standard that should have been followed under the undisputed facts of this case was the timely giving of this simple, harmless pressure test to this plaintiff and that, in failing to do so, the defendants were negligent, which proximately resulted in the blindness sustained by the plaintiff for which the defendants are liable.

There are no disputed facts to submit to the jury on the issue of the defendants' liability. Hence, a discussion of the plaintiff's proposed instructions would be inconsequential in view of our disposition of the case.

The judgment of the trial court and the decision of the Court of Appeals is reversed, and the case is remanded for a new trial on the issue of damages only.

**Hale, C.J., and Rosellini, Stafford, Wright, and Brachtenbach, JJ., concur.**
Utter, J. (concurring)—I concur in the result reached by the majority. I believe a greater duty of care could be imposed on the defendants than was established by their profession. The duty could be imposed when a disease, such as glaucoma, can be detected by a simple, well-known harmless test whose results are definitive and the disease can be successfully arrested by early detection, but where the effects of the disease are irreversible if undetected over a substantial period of time.

The difficulty with this approach is that we as judges, by using a negligence analysis, seem to be imposing a stigma of moral blame upon the doctors who, in this case, used all the precautions commonly prescribed by their profession in diagnosis and treatment. Lacking their training in this highly sophisticated profession, it seems illogical for this court to say they failed to exercise a reasonable standard of care. It seems to me we are, in reality, imposing liability, because, in choosing between an innocent plaintiff and a doctor, who acted reasonably according to his specialty but who could have prevented the full effects of this disease by administering a simple, harmless test and treatment, the plaintiff should not have to bear the risk of loss. As such, imposition of liability approaches that of strict liability.

Strict liability or liability without fault is not new to the law. Historically, it predates our concepts of fault or moral responsibility as a basis of the remedy. Wigmore, Responsibility for Torts: Its History, 7 Harv. L. Rev. 315, 383, 441 (1894). As noted in W. Prosser, The Law of Torts § 74 (3d ed. 1964) at pages 507, 508:

There are many situations in which a careful person is held liable for an entirely reasonable mistake. . . . in some cases the defendant may be held liable, although he is not only charged with no moral wrongdoing, but has not even departed in any way from a reasonable standard of intent or care. . . . There is “a strong and growing tendency, where there is blame on neither side, to ask, in view of the exigencies of social justice, who can best bear the loss and hence to shift the loss by creating liability where there has been no fault.”

(Footnote omitted.) Tort law has continually been in a state of flux. It is “not always neat and orderly. But this is not to say it is illogical. Its central logic is the logic that moves from premises—its objectives—that are only partly consistent, to conclusions—its rules—that serve each objective as well as may be while serving others too. It is the logic of maximizing service and minimizing disservice to multiple objectives.” Keeton, Is There a Place for Negligence in Modern Tort Law?, 53 Va. L. Rev. 886, 897 (1967).

When types of problems rather than numbers of cases are examined, strict liability is applied more often than negligence as a principle which determines liability. Peck, Negligence and Liability Without Fault in Tort Law, 46 Wash. L. Rev. 225, 239 (1971). There are many similarities in this case to other cases of strict liability. Problems of proof have been a common feature in situations where strict liability is applied. Where events are not matters of common experience, a juror’s ability to comprehend whether reasonable care has been followed diminishes. There are few areas as difficult for jurors to intelligently comprehend as the intricate questions of proof and standards in medical malpractice cases.

In applying strict liability there are many situations where it is imposed for conduct which can be defined with sufficient precision to insure that application of a strict liability principle will not produce miscarriages of justice in a substantial number of cases. If the activity involved is one which can be defined with sufficient precision, that definition can serve as an accounting unit to which the costs of the activity may be allocated with some certainty and precision. With this possible, strict liability serves a compensatory function in situations where the defendant is, through the use of insurance, the financially more responsible person. Peck, Negligence and Liability Without Fault in Tort Law, supra at 240-41.

If the standard of a reasonably prudent specialist is, in fact, inadequate to offer reasonable protection to the plaintiff, then liability can be imposed without fault. To do so
under the narrow facts of this case does not offend my sense of justice. The pressure test to measure intraocular pressure with the Schiotz tonometer and the Goldman applanometer takes a short time, involves no damage to the patient, and consists of placing the instrument against the eyeball. An abnormally high pressure requires other tests which would either confirm or deny the existence of glaucoma. It is generally believed that from 5 to 10 years of detectable increased pressure must exist before there is permanent damage to the optic nerves.

Although the incidence of glaucoma in the age range of the plaintiff is approximately one in 25,000, this alone should not be enough to deny her a claim. Where its presence can be detected by a simple, well-known harmless test, where the results of the test are definitive, where the disease can be successfully arrested by early detection and where its effects are irreversible if undetected over a substantial period of time, liability should be imposed upon defendants even though they did not violate the standard existing within the profession of ophthalmology.

The failure of plaintiff to raise this theory at the trial and to propose instructions consistent with it should not deprive her of the right to resolve the case on this theory on appeal. Where this court has authoritatively stated the law, the parties are bound by those principles until they have been overruled. Acceptance of those principles at trial does not constitute a waiver or estop appellants from adapting their cause on appeal to such a rule as might be declared if the earlier precedent is overruled. *Samuelson v. Freeman*, 75 Wn.2d 894, 900, 454 P.2d 406 (1969).

FINLEY and HAMILTON, JJ., concur with UTTER, J.

Petition for rehearing denied July 31, 1974.
APPENDIX C

The reader may be wondering how a case might read in the "law books" and therefore, the following case of *Holmes v. Iwasa* is included to satiate the reader's curiosity.
REASONABLE OPPORTUNITY

Had the legislature purported to make the shortened time applicable to accrued rights—which it did not do—and had it enacted as legislation that which the Court now establishes by judicial fiat, it would be difficult to uphold forty-five days as a reasonable time within which to bring a claim.

Although it is uncontested that legislatures have the power to shorten or lengthen statutes of limitation, the majority fails to recognize that courts in turn will make a determination of the reasonableness of the new time allowed to assert a claim when applied retroactively to a previously accrued right. Indeed, several cases cited by the Court in support of its position prescribe such an examination. In Olivas v. Weiner, 127 Cal.App.2d 597, 274 P.2d 476 (1954), the court qualified its application of a new statute of limitation to an accrued cause of action: "It has repeatedly been held that the legislature may reduce a statute of limitations and that the new period applies to accrued causes of action provided a reasonable time is allowed within which to assert the cause." 274 P.2d at 478 (emphasis added). In that instance, a new limitation of six years was held not unreasonable. After adopting almost identical language as found in Olivas, the Supreme Court of Utah in Greenhalgh v. Payson City, 530 P.2d 799, determined a new one-year limitation to be reasonable. See also Day & Night Heating Co. v. Ruff, 19 Utah 2d 412, 432 P.2d 43 (1967) (new one-year limitation held reasonable); Earle v. Froedtert Grain & Malting Co., 197 Wash. 341, 85 P.2d 264 (1938) (new six-month limitation held reasonable).

The lack of any holding by the majority, or any discussion whatever, regarding the reasonableness of the time period allowed for filing, in contravention of the very authority cited in support of its position, compels me to address the question, albeit in dissent. I am wholly unable to see that a forty-five day statute of limitation is a reasonable amount of time to assert an accrued claim which at the time of its accrual was subject to a one-year limitation. Forty-five days is not a long time in most circumstances. It is an exceedingly short period of time in which to by happenstance learn that the legislature has without fanfare shortened a one-year statute to a bare forty-five days. It cannot be said as a matter of law that the appellants' filing on November 5, 1976, approximately two and one-half months after the expiration of the forty-five day period as creatively applied by the Court, is unreasonable. Certainly, four months is not an excessive amount of time to allow a plaintiff who thinks he has one year to discover a change in the law and file a claim or notice. The Court's opinion has impermissibly, but effectively, foreclosed the appellants' opportunity to recover the benefits statutorily due medical indigents, yet no fault has been found against them.

104 Idaho 179
William HOLMES, Plaintiff-Appellant,
v.
George IWASA, Optometrist; Berkley Bio-Engineering International, a corporation, or Berkley Bio-Engineering, Inc.; Does I through XV; Does XVI through XXX; Does XLI through XL; Black Corporations I through XV; White Corporations I through XV; and Green Corporations I through XV, Defendants, and

George Iwasa, Optometrist,
Defendant-Respondent.

No. 13459.
Supreme Court of Idaho.

Patient brought action against optometrist for alleged professional malpractice.
The District Court, Third Judicial District, Fayette County, Edward J. Lodge, J., entered summary judgment for optometrist, and patient appealed. The Supreme Court, Bakes, J., held that although dates on which optometrist ordered bifocals for patient and fitted them to patient's head fell within two-year period of limitations set by professional malpractice statute, where there was no evidence that optometrist had a medical duty to reexamine or retest patient's eyes on those dates, and earlier dates on which he did examine patient's eyes were outside period of limitations, optometrist was not responsible for any occurrence, act or omission, i.e., failure to diagnose patient's glaucoma, on a date within two-year period of limitations, and patient's claim for professional malpractice was barred.

Affirmed.

Shepard, J., dissented and filed opinion in which Bistline, J., concurred.

1. Physicians and Surgeons = 18.15

Although dates on which optometrist ordered bifocals for patient and fitted them to patient's head fell within two-year period of limitations set by professional malpractice statute, where there was no evidence that optometrist had a medical duty to reexamine or retest patient's eyes on those dates, and earlier dates on which he did examine patient's eyes were outside period of limitations, optometrist was not responsible for any occurrence, act or omission, i.e., failure to diagnose patient's glaucoma, on a date within two-year period of limitations, and patient's claim for professional malpractice was barred. I.C. § 5–219, subd. 4.

2. Limitation of Actions = 13

In a proper case, a defendant may be stopped from relying on a statute of limitations as a bar to an action against him.

3. Limitation of Actions = 13

Estoppel may prevent a defendant from asserting the statutory bar when his representations or conduct dissuade a plaintiff from prosecuting his cause of action during the period of limitations.

4. Limitation of Actions = 13

Optometrist, against whom patient alleged professional malpractice for failure to diagnose glaucoma, was not estopped from relying on two-year period of limitations as a bar to action where, aside from fact that there was no evidence that optometrist made any statements or took any action in an effort to induce patient to delay in bringing action, there was no evidence that patient relied on statements made by optometrist in waiting to file his action. I.C. § 5–219, subd. 4.

5. Constitutional Law = 249(3), 308

Physicians and Surgeons = 2


A.L. Lyons, of Lyons, Bohner & Chasan, Boise, for plaintiff-appellant.

Michael Moore, of Imhoff & Lynch, Boise, for defendant-respondent.

BAKES, Justice.

Plaintiff appeals from a summary judgment entered in favor of the defendant in this professional malpractice action.

The sequence of events is virtually undisputed. The dispute arises over when the plaintiff’s cause of action accrued and when the statute of limitations began to run in this case. The evidence before the district court indicated that plaintiff, William Holmes, initially went to the defendant, Dr. George Iwasa, an optometrist practicing in Weiser and Cambridge, Idaho, on July 24, 1974, for a routine eye examination. Plaintiff complained of headaches and sensitivity to bright lights, but defendant found that these problems for years.
plaintiff's glasses were at that time the correct prescription. However, the defendant anticipated that bifocals might be necessary in the future.

Holmes returned to defendant's office on November 19, 1975, again complaining of problems with bright lights and headaches, and that his vision was blurred. Defendant took a history from the plaintiff; conducted an eye examination, including a test for glaucoma which was accomplished by measuring eye pressure with a tonometer, and prescribed bifocals for plaintiff's problems.

Plaintiff delayed ordering his bifocals from Dr. Iwasa until December 22, 1975, when he returned to defendant's office. Plaintiff's eyes were not examined on that date; he merely chose the frames and ordered the already prescribed bifocals. The purpose of plaintiff's next visit to Dr. Iwasa's office was to pick up his bifocals on January 21, 1976. At that time, Dr. Iwasa did not examine plaintiff's eyes but merely fitted the new bifocals to plaintiff's head.

When the new bifocals failed to relieve his symptoms, plaintiff went to see Dr. Howarth, an ophthalmologist, on January 23, 1976. Dr. Howarth conducted eye examinations and informed plaintiff that, in his opinion, plaintiff was suffering from glaucoma. In his deposition, Dr. Howarth described plaintiff's condition as marked open-angle glaucoma and explained that glaucoma grows progressively worse the longer the condition is present. Dr. Howarth estimated that the glaucoma had been present in plaintiff for at least eight years prior to January 23, 1976.

On December 21, 1977, plaintiff filed complaint against defendant and Berkeley Bio-Engineering International, the manufacturer of the tonometer used by Dr. Iwasa in measuring the pressure in plaintiff's eyes. Berkeley was subsequently dismissed from this action. Defendant, in his motion for summary judgment, alleged that certain counts contained in plaintiff's complaint were inapplicable to a malpractice action and that plaintiff's complaint as a whole was barred by the statute of limitations. The lower court granted defendant's summary judgment motion, based on the statute of limitations, and plaintiff appealed.

Although plaintiff appellee presented several issues on appeal, they all relate to the central issue of whether the district court erred in granting defendant's motion for summary judgment on the ground that the statute of limitations barred plaintiff's claim.

Prior to March 24, 1971, I.C. § 5-219(4), the statute of limitations applicable to professional malpractice actions, in essence provided that an action had to be filed within two years of the alleged professional malpractice; the statute made no reference whatsoever to the interrelationship between the accrual of a cause of action and knowledge of a cause of action. Without the benefit of legislative guidance, this Court adopted the so-called "discovery exception" in cases in which foreign objects were negligently left in a patient's body. In *Billings v. Sisters of Mercy of Idaho*, 98 Idaho 485, 489 P.2d 224 (1964), we held that "the cause of action [in such cases] does not accrue until the patient learns of, or in the exercise of reasonable care and diligence should have learned of, the presence of [the] foreign object in his body." *Id.* at 489, 489 P.2d at 232. In *Renner v. Edwards*, 98 Idaho 836, 475 P.2d 530 (1969), *aff'd on rehearing*, we extended the discovery rule to cases of misdiagnosis and held that the statute of limitations did not begin to run until the patient knew or should have known of the physician's misdiagnosis.

However, soon after our decision in *Renner*, and perhaps partly in response thereto, that the tests were run and that the results, dated October 28, 1975, were normal, which, according to Dr. Howarth, ruled out hypoglycemia as having an effect on plaintiff's eyesight. Plaintiff, however, did not return to Dr. Howarth until January 23, 1976.
to, the legislature substantially amended I.C. § 5-219(4). 1971 Idaho Sess. Laws, ch. 180, § 1. By amending I.C. § 5-219(4), the legislature narrowed the scope of Renner and, in large part, defined when a cause of action accrues for the purposes of applying the statutory period of limitations in professional malpractice actions. Under amended I.C. § 5-219(4), the discovery exception first recognized by this Court in Billings v. Sisters of Mercy of Idaho, 86 Idaho 485, 389 P.2d 224 (1964), is limited to cases involving foreign objects and fraudulent concealment. In all other professional malpractice actions, "the cause of action shall be deemed to have accrued as of the time of the occurrence, act or omission complained of ..." The action must be brought within two years of that time.

The alleged negligent act, occurrence or omission complained of by the plaintiff is Dr. Iwasa's failure to discover plaintiff's glaucoma. The undisputed evidence establishes that Dr. Iwasa examined plaintiff's eyes only on two occasions, July 24, 1974, and November 19, 1975, both dates falling outside the two year period set out in I.C. § 5-219(4). No examinations were performed on plaintiff's two subsequent visits—December 22, 1975, when the bifocals were ordered, and January 21, 1976, when the glasses were fitted to plaintiff's head. Therefore, the question we must decide on appeal is whether, on this record, a material issue of fact exists concerning whether Dr. Iwasa negligently failed to diagnose plaintiff's glaucoma on either December 22, 1975, or January 21, 1976, the two appointment dates within the statutory period of limitations.

In ruling on a summary judgment motion, the facts are to be liberally construed in favor of the party opposing the motion; he is to be given the benefit of all favorable inferences which might reasonably be drawn from the evidence. Taylor v. Choules, 102 Idaho 222, 224, 628 P.2d 1056, 1059 (1981).

3. In ch. 180, § 2, the legislature declared that an emergency existed and that the amendment should become effective upon approval. 1971 Idaho Sess. Laws, ch. 180, § 2.

4. As amended, I.C. § 5-219 provides for a two year limitation on:

(4) An action to recover damages for professional malpractice, or for an injury to the person, or for the death of one caused by the wrongful act or neglect of another, including any such action arising from breach of an expressed warranty or implied covenant; provided, however, when the action is for damages arising out of the placement and inadvertent, accidental or unintentional leaving of any foreign object in the body of any person by reason of the professional malpractice of any hospital, physician or other person or institution practicing any of the healing arts or from the fact of damage has, for the purpose of escaping responsibility therefor, been fraudulently and knowingly concealed from the injured party by an alleged wrongdoer standing at the time of the wrongful act, neglect or breach in a professional or commercial relationship with the injured party, the same shall be deemed to accrue when the injured party knew or in the exercise of reasonable care should have been put on inquiry regarding the condition or matter complained of; but in all other actions, whether arising from professional malpractice or otherwise, the cause of action shall be deemed to have accrued as of the time of the occurrence, act or omission complained of, and the limitation period shall not be extended by reason of any continuing consequences or damages resulting therefrom or any continuing professional or commercial relationship between the injured party and the alleged wrongdoer, and, provided further, that an action within the foregoing foreign object or fraudulent concealment exceptions must be commenced within one (1) year following the date of accrual as aforesaid or two (2) years following the occurrence, act or omission complained of, whichever is later. The term 'professional malpractice' as used herein refers to wrongful acts or omissions in the performance of professional services by any person, firm, association, entity or corporation licensed to perform such services under the law of the state of Idaho. This subsection shall not affect the application of section 5-243, Idaho Code, except as to actions arising from professional malpractice. Neither shall this subsection be deemed or construed to amend, or repeal section 5-241, Idaho Code." (Effective March 24, 1971).

The record contains the deposition of Dr. Howarth, the ophthalmologist who ultimately discovered plaintiff's glaucoma. In response to questions regarding what constitutes treatment, Dr. Howarth stated that if a doctor examines a patient one day and several days later writes a prescription, the latter "would be classed as a treatment, and . . . when you order the glasses, you are instituting the treatment when the glasses are delivered and fit to the patient's face, and you have then completed the treatment as far as the treating of his refractive error is concerned." The record also contains Dr. Howarth's affidavit in which he stated:

"It is the opinion of this affiant that treatment of a patient commences with the first examination and continues on as long as the problem of the patient is not corrected by the first procedure of the physician or the provider of health care. Eyeglasses themselves are . . . a facet of the treatment."

Thus, the record indicates that Dr. Howarth felt that Dr. Iwasa's course of treatment continued throughout the series of appointments. The question, however, is not one of continuing treatment, because I.C. § 5-219(4), as amended, expressly states that any continuing professional relationship between the injured party and the alleged wrongdoer shall not extend the limitations period, we conclude that there is no showing in the record that Dr. Iwasa was responsible for any occurrence, act or omission, i.e., the failure to diagnose glaucoma, on a date within the two year limitation period set out in I.C. § 5-219(4).

Plaintiff further alleges that defendant is estopped to assert the statute of limitations as a defense. Plaintiff argues that he relied on Dr. Iwasa's representations that the bifocals should resolve his problems.

[2, 3] This Court very recently recognized that, in a proper case, a defendant may be estopped from relying on a statute of limitations as a bar to an action against him. Twin Falls Clinic & Hospital Bldg. v. Hamill, 103 Idaho 19, 644 P.2d 341 (1982), Estoppel may prevent a defendant from asserting the statutory bar when his representations or conduct dissuade a plaintiff from prosecuting his cause of action during the period of limitations. See Twin Falls Clinic & Hospital Bldg. v. Hamill, supra; see also, Glus v. Brooklyn Eastern Dist. Terminal, 359 U.S. 231, 79 S.Ct. 760, 3 L.Ed.2d 770 (1959); Stafford v. Schultz, 42 Cal.2d 1, 270 P.2d 1 (1954); Bowman v. McPheeters, 77 Cal.App. 2d 795, 176 P.2d 176 (1947).

[4] The trial court found that "this is not a proper case for invoking the estoppel doctrine." We agree. See McCoy v. Wesley Hospital & Nurse Training School, 188 Kan. 325, 362 P.2d 841 (1961); Central Heat, Inc. v. Daily Olympian, Inc., 74 Wash.2d 126, 443 P.2d 544 (1968). A search of the record reveals no evidence that Dr. Iwasa made any statements or took any action in an effort to induce plaintiff to delay in bringing suit. Nor, viewing the facts and inferences most favorably toward the plaintiff, is there any evidence that the plaintiff relied on statements made by Dr. Iwasa in waiting to file his action. Apparently not satisfied that the bifocals helped his condition, plaintiff went to see Dr. Howarth on January 23, 1976, just two days after his last appointment with Dr. Iwasa.
On that date plaintiff was informed that he suffered from glaucoma. Yet, he delayed until December 21, 1977, nearly 23 months after discovering his glaucoma, before filing this action. This delay cannot be attributed to the defendant. Because the record does not disclose any evidence giving rise to a material issue concerning whether Dr. Iwasa is estopped from asserting the statute of limitations, we agree with the trial court’s conclusion that this is not an appropriate case for estoppel.

[5] Plaintiff also alleges that I.C. § 5–219(4) is constitutionally infirm and attacks the statute as violative of both the due process and equal protection clauses of the United States Constitution. We find no such infirmities. Cf. Twin Falls Clinic Hospital v. Hamill, 108 Idaho 19, 644 P.2d 341 (1982) (finding no violations of due process or equal protection in I.C. § 5–214, the statute of limitations applicable to actions arising out of design or construction of improvements to real property).

We affirm the district court’s summary judgment entered in favor of the defendant on the basis that plaintiff’s claim was barred by the statute of limitations. Costs to respondent.

McFADDEN, J. (Ret.), and McQUADE, J. Pro Tem., concur.

SHEPARD, Justice, dissenting, in which opinion BISTLINE, Justice, concurs.

As set forth in the majority opinion, it is axiomatic that at the juncture of a motion for summary judgment all facts, together with all reasonable inferences arising therefrom, must be viewed in the light most favorable to the party opposing summary judgment. My view of the evidence and its legitimate inferences arising therefrom lead me to a different conclusion than that of the majority. I also differ from the majority’s interpretation of the applicable statute of limitations, I.C. § 5–219(4).

The majority focuses very narrowly upon Iwasa’s failure to diagnose glaucoma on the date of 7–24–74 or 11–19–75. It evidently ignores the appointments of 12–22–75 and 1–21–76 as totally irrelevant. My view of the facts construed most favorably to Holmes indicates the following. Holmes consulted Iwasa with a problem evidenced by headaches, vision blurring, and sensitivity to bright lights. It was ultimately determined that Holmes’ problems were the result of glaucoma. Iwasa proceeded to treat the problem, which he negligently ascribed to the need for bifocals. Iwasa’s treatment of Holmes continued through 1–21–76. Holmes testified of the January, 1976 appointment, “I asked him [Iwasa] if they would clear them—up the blurriness. And he said yes, they would.” Iwasa’s testimony regarding that appointment appears to support the testimony of Holmes. The ophthalmologist, Dr. Howarth, stated his opinion that: “Treatment of a patient commences with the first examination and continues on as long as the problem of the patient is not corrected by the first procedure . . . eyeglasses themselves are . . . facet of the treatment.”

Hence, it is my belief that when the facts and inferences are viewed most favorably to Holmes, Iwasa continued to treat Holmes through the January, 1976 appointment and, in failing to diagnose the glaucoma and instead attributing Holmes’ problems to the need for bifocal eyeglasses, was negligent through the January, 1976 appointment.

Support for that view of the facts is found in a line of cases from the state of Washington, commencing with Samuelson v. Freeman, 75 Wash.2d 894, 454 P.2d 406 (1969), wherein it is stated:

“(1) If malpractice is claimed during a continuous and substantially uninterrupted course of treatment for a particular illness or condition, the statute does not begin to run until the treatment for that particular illness or condition has been terminated.” Id., 454 P.2d at 410 (emphasis added).

I believe that the majority’s interpretation of I.C. § 5–219(4) is erroneous. That statute provides that an action sounding in professional malpractice, unless it falls within certain exceptions not pertinent
here, accrues "as of the time of the occurrence, act or omission complained of, and the limitation period shall not be extended by reason of any continuing consequences or damages resulting therefrom or any continuing professional or commercial relationship between the injured party and the alleged wrongdoer." (Emphasis supplied.)

It is my view that the majority's interpretation of the statute would lead to the following result. Assume a patient is having trouble with his elbow and consults an orthopedic surgeon. The surgeon takes x-rays, which, if examined properly, would indicate the presence of cancer in the elbow joint which, if immediately treated, could be totally cured. However, the doctor fails to diagnose and prescribes a course of treatment for the patient involving hot packs, exercise regimes, aspirin, cortisone shots, immobilization of the arm, etc. Over the next two years the patient gains no relief and continues to consult the doctor on a monthly basis who continues the same treatment. One month later the patient sees another doctor who diagnoses cancer which, now spread to the extent that the arm must be amputated. I believe that under the rationale of the majority, the failure to diagnose would be pinpointed during the patient's first visit and he would therefore be barred from an action regardless of the obvious continuing negligence.

It would be my view that a correct interpretation of the statutory language of "continuing professional or commercial relationship" should have application only to a situation where the continuing relationship had nothing to do with the patient's problem which was originally misdiagnosed by the doctor. If, for example, a female patient consulted a general practitioner with the same elbow problems outlined above and that doctor failed to diagnose the cancer, and the patient thereafter never consulted that doctor regarding the elbow problem, but the doctor a year or so later examined the woman over a course of months relating to a pregnancy and later delivered a baby, clearly, that would constitute a continuing professional relationship, but nevertheless would have nothing to do with a continuing course of negligent treatment.

Hence, although it might appear to the majority that Holmes' chances at trial for recovery is somewhat slim, nevertheless, I deem the granting of the motion for summary judgment to have been erroneous and the matter should be remanded for trial.

BISTLINE, J., concurs.

104 Idaho 185
Mark NELSON and Dorothy Nelson, husband and wife, Plaintiffs-Appellants, v.
NORTHERN LEASING COMPANY; Hugh C. Hawkes; Sherm Hawkes; Hewitt Hawkes and Delores Hawkes, d/b/a Marsh Valley Packing, Defendants-Respondents.
No. 13987.
Supreme Court of Idaho.

Parents of one-year-old killed when truck ran over her brought action against truck driver and others. The District Court, Sixth Judicial District, Bannock County, George W. Hargraves, J., entered judgment upon jury verdict which assigned to parents 60% of comparative negligence, and parents appealed. The Supreme Court, Shepard, J., held that jury could find that parents were 60% causally negligent.

Affirmed.

1. Death = 24

In wrongful death action, negligence of parents of deceased one-year-old struck by vehicle is affirmative defense. I.C. § 5-310.