

Letters

A Lifestyle Decision?

A new term is sneaking into the ophthalmic lexicon, and I would like to see it stopped before it gains traction. In several recent publications (though not *EyeNet*), some authors have used the term “lifestyle IOL” for accommodative, multifocal and toric IOLs.

Ophthalmologists should not be in the business of suggesting what constitutes the quality of a lifestyle or of implying that if patients fail to consider these high-end lenses, they are remiss or are lacking in a clear understanding of how to grab the “golden ring.”

Standard monofocal implants should also qualify for enthusiasm within this nebulous “lifestyle” moniker. My wife’s monofocal implant—supplemented with over-the-counter reading glasses—seems neither to limit nor compromise her appreciation of life in any way.

Lifestyle IOLs should be

called exactly what they are: bifocal implants, multifocal implants, accommodating implants or astigmatism-correcting implants. Our patients can easily understand this, and a reasonably intelligent conversation can ensue as to the advantages and disadvantages of all that is available. To casually throw the amorphous, fleeting and poorly quantifiable concept of “lifestyle” into the decision-making process smacks of business promotion at best and hucksterism at worst.

Neil D. Baronberg, MD
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Stick to the Classical Oath

I write to you regarding “Individual vs. Societal Needs: What’s a Physician to Do?” (Opinion, July/August). While your article does not surprise me, I was certainly disappointed by the view expressed.

My main disagreement is with your idea that the modern Hippocratic oath is really not an allegiance to an individual patient—that our view should be more broad and societal. I would certainly disagree with this conclusion.

Many challenges to the care of the individual patient will come from a government-run health system. (The modern Hippocratic oath, in fact, arose primar-

ily in the United Kingdom as their national health service was developed.) For example, in England, the government was not paying for Lucentis or Avastin injections in the first eye and was only offering this to patients when their second eye became involved. Are we going to be complicit in denying an 85-year-old, healthy individual an aortic valve surgery? This type of question will be a reality in a very short period of time.

Yours is an extremely dangerous set of beliefs. You, unfortunately, have surrendered the commanding height of the moral argument.

I pray that your view of the Hippocratic oath is not shared with the leaders of the Academy. I feel certain that the vast majority of the members of the Academy do not subscribe to your position. If there were a time that we should adhere to the classical oath, now is that time.

William R. Stiles, MD
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The Greater Good

Having just finished “Individual vs. Societal Needs:



Last month's issue is online at www.eyenetmagazine.org/archives.

What’s a Physician to Do?” (Opinion, July/August), I am impressed with how meaningful and prescient it is regarding the current condition of medicine and society.

Health care efficiency is definitely needed, and your statement that we should act “with a sense of societal responsibility even as we care for individual patients” indicates the direction which both our government and society should be looking.

I always enjoy reading all of your editorials, but this one is especially insightful and says much that needs to be said.

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