

Letters to the Editor

Which procedure, which eye?

In modern day-care ophthalmic surgical facilities, it is often difficult for the surgeon to meet with the next patient on the list before any preparation or anaesthesia is commenced. For the surgeon to meet the patient prior to any preparation, either all the patients would need to be present before the list begins, or each patient would need to have arrived before surgery had started on the previous patient.

The commonly used final safeguard to determine the correct procedure and side, namely the surgeon talking with the patient and marking the side, is thus not able to be done without either wasting surgical facility time or inconveniencing patients by having them arrive early.

We have recently adopted an idea from the Wills Eye Hospital in Philadelphia, USA, of having a stamp placed in the patient's chart at the time the patient is booked for surgery (Fig. 1).

In the day or two prior to a list, the surgeon goes through the charts and completes the stamped details, which serves as a final clear documentation of the surgical plan. It is a rule that no preparation, such as eye drops or local anaesthetic, is to begin unless the stamp has been completed and signed by the surgeon.

This procedure does not address the problem of the wrong record being associated with the wrong patient, this still must be verified by cross-checking name, address and date of birth. Nevertheless, in the setting of a high-volume day surgery facility, we believe that the simple but obligatory stamp adds another safeguard against error.

O Bruce Hadden FRANZCO

Eye Institute,
Auckland,
New Zealand

EYE: RIGHT / LEFT

OPERATION:.....

ANAESTHETIC: TOPICAL / LA / GA

SURGEON:.....

Figure 1. Stamp placed in patient's chart.

Health status of Lebanese ophthalmologists

Little is known about the health status of ophthalmologists. To this end, interviews were conducted with the ophthalmic community concentrating on medical and ocular problems as well as smoking habits. Smoking habits were compared to the general medical population via a second independent interview (designed to study smoking habits in health professionals) and to the national consumption.

All registered 171 ophthalmologists in Lebanon were interviewed by the authors (AMM, ATS, NGG) either in person (149) or by telephone (22). Lebanon has 6613 physicians consisting of 5500 men and 1113 women. A representative sample was selected (by FM and MG) covering 9.6% of Lebanese physicians. The sampling was performed by including all the small private hospitals (31 in number) in the five districts that form Lebanon. A person-to-person interview by second-year medical students was conducted with 635 practitioners filling a questionnaire. The questionnaire included age at initiation of smoking, smoking habits, attitude towards smoking and towards smoking campaigns, willingness to stop smoking, and awareness of smoking hazards (only the smoking habit will be discussed to compare ophthalmologists to medical practitioners).

The mean age of ophthalmologists was 43 years (range, 28–69 years) with a large male preponderance (93% men). Systemic disorders included: coronary heart disease (3.0%), hyperlipidemia (3.0%), spinal disc disease (3.0%), systemic hypertension (2.4%), diabetes mellitus (1.8%), kidney stone (1.2%), migraine (1.2%), hyperuricemia (0.6%), asthma (0.6%), sinusitis (0.6%), and pituitary adenoma (0.6%). Ocular disorders included: cataract (0.6%), optic nerve atrophy (0.6%), and keratoconjunctivitis sicca (0.6%).

Female ophthalmologists were all non-smokers. Smoking habits among male ophthalmologists included non-smokers (60.4%), smokers (27.7%) and ex-smokers (11.9%). Smoking in current smokers included cigarette (75.0%), cigar (13.6%), pipe (6.8%), and hubble-bubble (an Oriental pipe with a long hose; 4.6%) with mean pack-years of 16.3. Smoking in ex-smokers included cigarette (94.7%) and cigar (5.3%) with mean pack-years of 18.6.

The 635 non-ophthalmologist practitioners interviewed consisted of 450 men and 185 women (1 male and 2 female physicians refused to participate and were not included in the analyses). Male physicians were non-smoker (63.5%), smoker (36.2%), and non-responder (0.3%). Female physicians were non-smoker (81.6%), smoker (17.3%), and non-responder (1.1%). Male smokers consumed cigarette

(83.5%), pipe (13.1%), and others (3.4%), while female smokers consumed cigarette (92.3%) and pipe (7.7%). Physicians smoked less than 10 cigarettes (41.9%), between 10 and 19 cigarettes (24.3%), 20 cigarettes (23.8%), and more than 20 cigarettes (10%).

The high percentage of smokers among ophthalmologists was also found in Lebanese physicians (30% smokers) and in medical students (18% smokers in a 1998 survey of 238 participants at the American University of Beirut AUB; I Nuwayhid, PhD, AUB School of Public Health, unpubl. data). Besides the medical community, Lebanon has a very large smoking population with a huge national consumption. Lebanon has a population of 3.5 millions and consumes 10^9 cigarettes monthly (Tobacco Registry, pers. comm., July 1999) which is equivalent to a daily consumption of 10 cigarettes/person. There is a high proportion of smoking male physicians in the Middle East, as high as 45.3% in Kuwait or 43.9% in United Arab Emirates¹ compared to the rest of the world (18% in Malaysia,² 15% in New Zealand³ and 14% Austria⁴).

The Lebanese ophthalmic community appears relatively young with a low systemic morbidity, a very low ocular morbidity, and a high percentage of smokers. The low systemic and ocular morbidity may be related to either incomplete information retrieved from interviews or to the suspension of practice by disease-afflicted ophthalmologists.

Because of the recently described hazards of smoking on the eye (cataract, macular degeneration, worsening of

diabetic retinopathy and Graves' ophthalmopathy),⁵ ophthalmologists need to play a lead role among physicians by abstaining from smoking.

Ahmad M Mansour MD,¹ Ali T Shoughari MD,¹
Nicholas G Ghazi MD,¹ Farah Mokdad PharmD² and
Marwan Ghosn PharmD²

¹Department of Ophthalmology, American University of Beirut,
and ²School of Pharmacy, Saint Joseph University,
Beirut, Lebanon

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