# The medical (and legal) consequences of looking at your phone in bed

by Theodore Dalrymple

An extremely interesting little item in the *New England Journal of Medicine* caught my eye recently, if that is not an unfortunately expression in the circumstances. Two women, aged 22 and 40, were referred to Moorfields Eye Hospital complaining of recurrent transient blindness in one eye, and after a lot of sophisticated tests and investigations that turned up no answers, the neuro-opthalmologists came up with an ingenious and correct explanation.

The two women used to lie in bed with their smartphones looking at the screen: but with only one eye, the other covered by the pillow. The transient blindness always occurred in the eye that had been looking at the screen, not the one buried in the pillow. The blindness lasted for about 15 minutes.

It turned out that the women's two eyes were differentially adapted, one to the light and the other to the dark. When they stopped looking at the screen and turned off their telephones, their light-adapted eye took time to adapt to the dark and appeared blind by comparison with the one already dark-adapted. Their transient blindness, at first so worrying, was not at all sinister.

This was a very clever explanation and illustrates the value of taking a careful and detailed history from the patient. The first inclination of doctors these days is to put their patients straight into what a physician in my old hospital called 'the answering machine' – that is to say a scan into which the patient disappears temporarily, the answer (that is

to say, the diagnosis) coming straight out like a sausage from a sausage machine.

Far be it from me to decry scans. I'd want one myself if there were anything wrong with me other than occasional low back pain that a scan would persuade a surgeon to treat surgically, especially if I were a-private patient. No, modern medicine is best.

However, I was not altogether convinced by one statement in the same article. The authors wrote: 'We present two cases in which careful history taking established a benign cause [of transient monocular loss of vision]. '

Then, near the end, they say: 'Smartphones are now used nearly around the clock, and manufacturers are producing screens with increased brightness to offset background ambient luminance and thereby allow easy reading.'

This doesn't sound all that benign to me, at least in the wider, non-ophthalmological sense. Smartphones in bed! It reminds of the famous line in George Mikes' book *How to Be an Alien*: 'Continentals have sex; the English have hot water bottles.' Of course times have changed: smartphones have replaced hot water bottles. Is this progress?

I confess that I too have moved with the times and take my phone with me to bed. If I wake in the night I reach out to it straight away and peer at it (always with both eyes, however), though I do not recall a single message that imperatively had to be answered at three in the morning: I am not the kind of person to whom such messages are sent. What, indeed, could such a message be? Yet, like so many people, I labour under a strange compulsion never to be too much out of reach of electronic communication. However much I deplore those foolish and unattractive people in restaurants and trains and libraries and streets who are far more interested in their little screens than what is going on around them, I am only a

few degrees removed from them and no doubt would have been one of them had I been born a little later in the 20th century.

How long can it be before the sixth edition of the *Diagnostic and Statistical-Manual* of the American Psychiatric Association discovers (or is it invents?) a new disease; one of Screen Separation Anxiety? Psychiatric disorders are a bit like human rights in that they keep increasing in number all the time and no one knows whether this represents an increase in human knowledge and compassion or an increase in credulity and rent-seeking by certified professions.

Anyhow, it would be easy to list the-criteria for the diagnosis of SSM in the normal manner of the DSM: Severe or incapacitating anxiety on being separated from screens for more than two hours, with at least three of the following: a) Excessive time spent looking at screens (except for work); b) Reduced normal social interaction because of time spent looking at screens; c) Inability to concentrate on anything except a screen; d) Preference for screens over all other activities; e) Anger at suggestions that less time should be spent looking at screens; f) Inability to refrain from looking at screens when one or more is nearby.

AND at least one of the following: 1) Serious interference with social or work performance; 2) Insomnia caused by proximity of screens consulted through the night.

Where DSM leads, tort law soon follows; and judges, with all the credulity of Latin American peasants praying on their knees before miracle-working Virgins, will accept the diagnosis of SSM as bona fide and as veridical as a new species of fish-discovered at a depth of 20,000 feet, simply because it appears in the DSM.

The crucial question in tort law is not who has done wrong, but who has the most money. There is no point in suing someone who is without a bean, however responsible for the alleged

injury he may have been. Luckily for victims of SSM, the plausibly responsible defendants are some of the richest organisations in the world, who can easily afford to buy off plaintiffs. It will be easy to show that these organisations are owned or managed by people who send their own-children to private schools where access to computers and mobile telephones in particular are not allowed, and that they were therefore fully aware of the harmful effect on children (and others) of their own products.

It’s not my fault that I look at my emails in the middle of the night; it is time for a touch of class action.

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