

Ethics in Optometric Practice- the Obligations that Define a Profession

Dear Editor:

THE DEFINING FEATURE OF A PROFESSION

The use of the word 'profession' has expanded so far beyond its original meaning that a clear definition has become obscured and marred by colloquial usage¹. It is not uncommon to find the term 'professional' misused to describe sportsmen, tradesmen and even politicians. Yet, when we speak about a 'professional' there is a tacit understanding that only individuals engaged in certain occupations belong to that category: doctors, lawyers, teachers. A fundamental distinction between a profession and any other occupation, is that individuals engaged in a profession have an ethical obligation to whomever they offer their services. In other words, a profession is required to have a Code of Ethics.

THE ORIGIN OF ETHICAL CODES

Optometry ranks amongst the leading healthcare professions and various national Codes of Ethics for Optometry exist¹. These can all be traced back to one of the original sources of medical ethics in the Western world: the famous oath of Hippocrates¹. Hippocrates lived around 460-380 BC and was believed to be part of a physician's cult in ancient Greece who were faithful to Asclepius, the god of medicine and healing. Indeed, the memory of the worship of Asclepius lives on in modern medicine: the snake around the physician's staff is attributed to this god as snakes were part of the ancient healing ritual. Whilst reptilian remedies do not form part of medicine and healthcare today and Hippocrates original oath (as we understand it through modern translations²) includes statements that would not concord with modern practice: e.g. a pledge to remain chaste and religious and never to procure abortion², the essence of the Hippocratic oath endures in current principles of medical and healthcare ethics.

The oath has been transposed through history and more recently was incorporated into the Declaration of Geneva (1948) that followed the aftermath of the Second World War¹. The following year, in response to Nazi War Crimes, the World Medical Association adopted The International Code of Medical Ethics¹. This has formed the basis of the codes of ethics of a number of healthcare professions.

ETHICAL PRINCIPLES

The ethical codes contain guiding principles. These serve to help practitioners in their decisions and in practi-

ing in accordance with a set of standards that are expected of a healthcare practitioner. Beauchamp and Childress³ cite beneficence, non-maleficence, respect for autonomy and justice as the four major ethical principles in healthcare. These principles can be described as follows:

(i) Beneficence is striving to do good and to do the best for every patient. This recognises that a practitioner has a duty of care to every patient and that paramount is the objective to do good so that every patient leaves the practice in a better state than when they entered, or at the very least, not in a worse condition.

(ii) Non-maleficence, directly traceable to the Hippocratic oath ("above all to do no harm")¹, is about the avoidance of harm. This requires balancing risks and benefits of treatment and making decisions that will optimise the benefits and minimise the risks of harm.

(iii) Respect for autonomy requires a practitioner to respect the choices and decisions that a patient makes about his/her own health. This involves keeping the patients informed of their condition, treatment choices and options so that decisions made are based on pertinent facts.

(iv) Justice entails being fair to all patients in a way that transgresses legal justice. It includes deciding how much time is spent on a patient, how many and what types of resources are devoted to treatment of that patient and how this compares to the time and resources distributed to other patients.

In addition to beneficence, non-maleficence, respect for autonomy and justice, the principles of confidentiality, protection of the vulnerable and collegiality have been included to form the ethical principles that should guide optometric practice¹. Confidentiality means non-disclosure of patient details and health records in order to respect the privacy and preserve the dignity of each patient. Like non-maleficence, it can be traced directly to the Hippocratic oath: "Whatever I see or hear, professionally or privately, which ought not to be divulged, I will keep secret and tell no one"¹.

Protecting the vulnerable involves standing up for the rights of those who may be unable to speak or act for themselves. Although all patients are to some extent vulnerable for they come for help to the practitioner, some are more vulnerable than others. These include children, the frail elderly and patients who are unable to make decisions for themselves. Whilst some of these patients may not be considered autonomous by law (such as children) and others may be mentally unable to exercise autonomy, their dignity must at all times be respected and the duty of care the practitioner owes them may require a degree of protection that extends beyond the usual duty of care.

Collegiality calls for support of colleagues and fellow practitioners and professionals. This is the only ethical principle that does not apply to patients but to the way practitioners treat one another. Collegiality means mutual respect and understanding for fellow optometrists, for other professionals and for their respective roles in the health care team.

THE PROBLEM WITH ABSOLUTE APPLICATION

Each of these principles would appear to be sound and simple to follow, almost too obvious to need stating. Yet, for each one of them situations that may render that principle limiting or difficult to apply will arise. This illustrates the paradox that whilst these principles are essential tools for ethical practice, if applied too rigidly, they can be problematic. No principle can be applied absolutely. Take the example of beneficence. It is easy to say that a practitioner should at all times do his/her best for a patient but it is not so simple to define how good is good enough? Should a practitioner become so completely selfless that (s)he commits his entire life and all available time to helping patients at the expense of a private life and duties to family? The difficulty with beneficence is that it is limitless and every practitioner needs to decide how far (s)he wants to take this principle.

Non-maleficence may not be limitless but it may be limiting. No practitioner will ever set out to harm a patient, yet certain practice methods will incur a risk of harm: contact tonometry or the prescription of a contact lens can result in unwanted side effects. To apply non-maleficence rigidly would require a practitioner to abandon all practice methods with the potential of harm, no matter how minimal the harm or how small the risk. This would limit the practitioner to such an extent that optometric practice may not be feasible.

Respecting the autonomy of a patient who refuses to wear a prescription without which (s)he is below the legal standard for driving, can pose difficulties. Can the optometrist always respect the choice of a patient whose behaviour may be unreasonable and potentially dangerous? More poignant illustrations of limits on autonomy are seen in cases of patients who are suffering from debilitating and painful conditions and wish to die. In many countries, where euthanasia is illegal, such patients' wishes cannot be respected.

Justice means being fair to all patients but that involves the complexity of deciding the basis of this fairness and how time and resources should be distributed. It would be easiest to say that all patients should be given half an hour of an optometrist's time but this may prove to be too inflexible: some patients may need less time and some considerably more. Similarly, it may sound just to declare that the same treatment should be given to patients with the same condition. How is this to be reconciled in the case of a ninety year old lady with cataracts that leave her with visual acuity of 6/18 and the forty year old long distance driver with the same type of cataract and same visual acuity? Should both necessarily be referred for cataract surgery?

Confidentiality may be compromised when a patient discloses to a practitioner something that may have serious ramifications for the patient and potentially for others. It can be very difficult for an optometrist to decide whether or not to keep confidential the details of a patient who admits to having AIDS but asks the optometrist to keep this secret from his (the patient's) wife.

Protecting the vulnerable may require deciding how far this protection can extend. Should the parent of a child patient who appears with multiple bruising be reported even though the matter has nothing to do with eye care? Reporting such a matter to social services may result in innocent parents having to defend themselves against charges of child abuse. Not reporting, may leave a vulnerable child open to further risk of harm.

Collegiality is easy to practice with those who have similar interests and outlooks. It can be more difficult when working with a fellow optometrist who has different perspectives, opinions, attitudes and behaviour. If the colleague is practicing ethically, personal differences should be put aside. Collegiality also has no place for prejudice or professional jealousy. If a colleague is behaving in a manner that may be inappropriate for a professional, collegiality cannot be used as an excuse to protect what is wrong. Help should be offered but in some cases a colleague may need to be reported.

ETHICAL DILEMMAS

In addition to situations that complicate the application of each principle, there will be circumstances that cause principles to conflict: applying one will almost certainly require disregarding another. In such cases, the practitioner is confronted with an ethical dilemma.

This is obvious in the case of an overweight diabetic who presents to the optometrist with early signs of retinopathy. The patient is a smoker and is reluctant to stop this habit claiming that he needs to smoke to try to reduce his weight. Beneficence requires the practitioner to do his/her best for the patient. The very best is clearly to do whatever is possible to alter the lifestyle of the patient. Yet, the patient insists that he will continue to smoke and the practitioner is also obliged to respect the patient's choices. The conflict between beneficence and respect for autonomy is clear. It is also clear that in such a case a practitioner cannot enforce smoking cessation on the patient. The best that can be offered is advice. The autonomy of the patient and respect for his choices presides over a more active application of beneficence.

A less obvious dilemma arises in the case of a patient requesting treatment about which the practitioner has reservations. How does a practitioner, who is concerned about the risks of orthokeratology in young patients, respond to the parents of a young myope who have heard about the alleged beneficial effects of orthokeratology in retarding the progression of myopia and insist on this method of correction being prescribed for their child? The dilemma between non-maleficence, respect for autonomy and protection of the vulnerable is evident. What may be

less evident is the dilemma that a practitioner faces when research about a method is conflicting and, therefore, presenting patients with reliable information is, not possible.

CONCLUSIONS

Unlike laws and regulations, which are prescriptive and rigid, the principles of ethics are flexible and how they are applied depends on the individual practitioner. This places on each optometrist: a) the responsibility of developing personal ethical standards and b) the expectation of possessing the requisite self-discipline to practice in accord-

ance with these standards. It is these responsibilities and expectations that are the hallmarks of a profession.

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