

Professionalism and Professional Ethics

A Distance Education Module

Prepared for the College of Optometrists of Ontario

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Introduction

Professionals play important roles in all our lives. We trust engineers to build safe bridges, accountants to carry out diligent audits of our financial institutions, lawyers to defend us competently in court, and health professionals to diagnose and treat our illnesses. The trust that we place in professionals gives them enormous power; with that power comes significant responsibility.

As a health professional, you are likely aware of this special responsibility. Acknowledging this responsibility is a good start: it means that you are more likely to be attentive to the ethical dimension of your practice.

This discussion will be broken into 4 sections. The first section will ask, what is a professional? That is, what distinguishes professions from other occupational groups? The second section will ask, what are the ethical implications of professionalism? The third section will comment briefly on ethical issues specific to the practice of optometry. Finally, the fourth section will explore the question of ethical decision-making, and suggest several models and decision-making heuristics. Also included is an Appendix containing suggested resources for further study.

Section 1: What *is* a Professional?

Let us begin with a question that never occurs to most people: "What is a professional?" Many people make claims to being professionals these days. Open up the Yellow Pages and you'll find companies that offer "Professional Carpet Cleaning" or "Professional Auto Repairs." Further, we

often use the term "professional" to describe anyone who does some particular thing *for a living*, as opposed to doing it merely recreationally. For example, we differentiate between amateur and *professional* hockey players. But normally when we speak of "professionals" (or "Professionals" with a capital "P") we are speaking of groups such as Physicians, Lawyers, Engineers, Nurses, Foresters, and Optometrists.

What is it that differentiates "the professions" from other occupational groups? Different professional groups vary widely, but there are certain characteristics shared by all groups that we generally think of as professions. Other occupational groups may have one or several but not all of these. We can generally identify the following main characteristics:

A Professionals Provide a Socially Important Service

Optometrists, like Lawyers, Doctors, Foresters, and other groups labelled as "professionals," perform tasks that are considered socially valuable. That is, the services rendered by the profession as a group are valuable not just to individuals, but to society as a whole. It is of general social benefit to have a system for the reliable provision of ocular health, just as it is of general social benefit to have a functional legal system. Modern high-speed transportation would be impossible without the services of engineers. And large-scale financial services would be impossible without accountants.

B Professionals Have an Esoteric, Theoretical Knowledge Base

Professionals have a complex knowledge base and set of skills. Their knowledge is typically esoteric and theoretical (that is, it usually does not consist of facts that a lay-person could easily look up in a book, for example). The application of professional knowledge typically requires considerable judgment, and the tasks carried out by professionals are not usually the kinds of tasks that could be mechanized. The principles of legal reasoning, for example, can only be learned through years of study and practical experience. The same is clearly true of the principles of ocular health. Clinical judgment, based on theoretical knowledge and practical experience, is central to the practice of Optometry. Professionals typically also have skills that an amateur could not easily master. For example, if I had the time and interest I could learn to repair my own car; I could not as easily learn to diagnose defects in my own vision.

C Professionals Have Extensive Formal and Practical Training

Professional training typically involves at least several years of university training. And before professional practice is allowed to begin, there is often also a period of supervised practice. Physicians, for example, spend several years as Interns and Residents. Lawyers spend a year "articling." Before being allowed to practice, professionals typically also undergo special testing (Bar Exams for lawyers, for example, or the examinations required by the College of

Optometrists) to demonstrate their competency. Professionals are typically also expected to undergo continuing education and updating of their knowledge, throughout their professional careers.

D Professionals are Self-Regulating

Society typically allows professions to regulate themselves. That is, all professions are governed by associations or colleges (consisting of members of the profession) that regulate admission to the profession (through registration or the issuing of licences), and enforce both technical standards and ethical standards among their membership. These associations are typically provincially chartered bodies with considerable legal power (for example, the College of Optometrists of Ontario is granted authority, under Ontario's *Regulated Health Professions Act* and *Optometry Act*, to regulate the practice of Optometry in Ontario). For example, professional regulators have the power to grant licences to practice and the right to use professional titles. This power gives these groups significant control over their particular field of practice. This means that it is usually illegal for non-members to offer the same services as those offered by members of the profession. Anybody, for example, may call themselves a philosopher and offer to solve philosophical problems; but it is *illegal* to call yourself an optometrist or to offer optometric services if you are not registered to do so. Professional regulators also have the responsibility to develop the technical and ethical standards that their members must

meet, and are empowered by law to discipline their members in various ways if professional behaviour falls below the acceptable minimum established by the profession.

E Professionals Acknowledge a Special Responsibility to the Public

Professionals are typically seen as having a special responsibility not just to their particular employers or clients or patients, but also to society as a whole. This is seen, for example, in the fact that many professional codes of ethics indicate that a professional's *first* duty is to "the public good" or "the health and safety of the public" or some such. In practice, the obligation to promote the public interest is typically borne by professional associations and regulatory bodies; the means by which individual professionals serve the public good is through dedicated service to their own patients or clients.

This special obligation to the public is sometimes described as being owed to the public as part of a "contract" with society. Individual professionals often enjoy considerable social prestige, significant financial rewards, and a high degree of autonomy in their work. And, as mentioned above, professionals as a *group* are given the privilege of self-regulation. In return, professionals are said to owe a high degree of loyalty to the society that grants these privileges. Note that this "contract" need not take the form of a formal, written document (although some aspects of the profession will typically be legislated – see, for example, Ontario's *Regulated Health Professions Act*). But, ethically speaking, it is better to think of this "contract" as an *unspoken understanding*, a description of what

each of the two parties is expected to contribute, and what each can reasonably expect to gain.

Section 2: Ethical Implications of Professionalism

Identifying the characteristics that distinguish professions from other occupational groups would be primarily an academic exercise, were it not for the fact that, together, the characteristics imply special ethical obligations. There are two important factors to note with regard to the moral obligations of professionals.

First, professionals are often seen as having special obligations on account of the special roles they play. That is, a professional may have obligations that a non-professional might not have in the same situation. For instance, in some jurisdictions physicians are expected (and sometimes legally required) to lend assistance if they come across an accident scene; "ordinary" people, on the other hand, are not typically thought to have a duty to help (though it is generally thought to be a good thing when they do).

Second, professionals are often held to a *higher standard* than non-professionals, at least in certain circumstances. For example, while we might expect only a minimal degree of honesty from someone trying to sell us a stereo, we typically expect an accountant to be both fully honest and indeed open and candid in her/his evaluation of the financial status of a company in which we are thinking of investing. Likewise, patients expect Optometrists to be more than minimally honest in assessing the patient's ocular health, in rendering professional advice

and in recommending treatment. This heightened expectation shows up in particular in those instances in which professionals are accused of wrongdoing. We may be angry to find out that a salesman has misled us about the quality of a refrigerator we are buying, but we would be shocked to find out that our pharmacist had misled us about the effectiveness of a drug that she dispensed. We may be upset to find out that a janitor has abused a child, but we are *outraged* when we find out that a physician has done so.

We noted above that one of the characteristics of professionals is that they are typically seen as being party to a contract with society. Under the terms of this unwritten contract, professionals are given a monopoly over a particular field of practice, and in return professionals are expected to show special concern for the public good. This "social contract" implies that professionalism consists of not just technical expertise, but also a set of special ethical and social obligations.

What accounts for the fact that we give professionals special obligations and hold them to higher standards?

The fact that we typically hold professionals to a higher standard can be attributed to two factors. The first factor is the social contract discussed above. In exchange for the privileges that being a professional brings, we demand a level of ethical conduct above that of the average self-interested individual. The second factor has to do with the great power inherent in professional practice. One of the characteristics noted above is that professionals have expertise that lay persons do not. This lack of knowledge puts us at a disadvantage in our

dealings with professionals. A discussion between an Optometrist and her/his patient (say, over treatment options) is significantly different from negotiations between someone selling a house and a potential buyer.

Further, we rely upon professionals to exercise their expertise in matters that are of the highest importance to us. We trust teachers with the education of our children. We trust our lawyers to ensure that we receive the full protection of the law. We trust foresters to safeguard our forest ecosystems. We entrust nurses and physicians with our very lives. And we entrust Optometrists with our eyes, the organs responsible for what many consider to be the most precious of the senses. This trusting relationship produces what have come to be known as "fiduciary" obligations. Significantly, the term "fiduciary" comes from the Latin word meaning "to trust."

Section 3: Ethics in Optometry

Ethics in Optometry is part of the more general topic of health care ethics, or what is sometimes referred to as "bioethics." Many of the ethical issues faced in Optometry – confidentiality, conflict of interest, etc. – are challenges shared in common with other health care professions. But a few factors distinguish ethics in Optometry, so it is worth mentioning those.

One issue of special interest to Optometrists is that of conflict of interest. A conflict of interest may be defined as "a situation in which a person has a private or personal interest sufficient to appear to influence the objective exercise of his or her official duties as, say, a public official, an

employee, or a professional.”¹ Of course, conflicts of interest may arise in any of the health professions, and in other fields as well. The fact that most Optometrists’ services include dispensing ophthalmic appliances means that financial issues may be more complicated, and sometimes more muddled, than is the case for other professionals. This issue warrants careful attention, both by individual Optometrists and by the College. It is crucial to the continued good reputation of the profession, and to the ocular health of the patients it serves, that Optometrists be seen to provide care in a manner that puts the health of patients first, and personal financial gain a distant second.

Another noteworthy special issue is related to vision and driving. Ontario’s *Highway Traffic Act* requires Optometrists to report, to the Registrar of Motor Vehicles, any patient who has “a visual impairment that may make it dangerous for the person to operate a motor vehicle.” A similar requirement is found in the *Aeronautics Act*. Legal requirements are not *the same* as ethical requirements, but there is a large area of overlap that includes the obligations implied by these two pieces of legislation. As part of their general obligation to serve the public interest, Optometrists help to ensure that public safety is not compromised by drivers or pilots with impaired vision.

Finally, a word needs to be said about the relative obscurity of Optometric ethics. For various reasons, optometry does not have the high public

profile that medicine or nursing does. Partly because of this, optometric ethics have not been thrust into the limelight. This is a good thing, to the extent that it implies that the profession’s good reputation has not been tarnished by controversy and scandal. But this relative obscurity also has a down-side, and this is that it is too easy for optometrists to assume that there are no significant ethical issues in optometry, or that the ethical issues there are, are relatively trivial. It is too easy to think that such ethical issues as arise from time to time can be dealt with off-the-cuff. Of course, when you think about it, you see that ethical issues are the bread and butter of clinical practice. Optometrists make, on a daily basis, decisions that affect people’s well-being, that prioritize the needs of various patients, and that decide how to balance competing professional and personal obligations. For the most part, such decisions are made effortlessly and made well, by Optometrists guided by professional standards and a commitment to serve. But cases will arise, in any professional’s career, that test your dedication, and that push the limits of both intuition and professional principles. The document you are reading and the cases that accompany it are intended to help prepare you for those.

Section 4: Ethical Decision-Making

There is no one right way to approach ethical decision-making. There are, of course, better and worse ways to approach it. Better approaches help us to be more reflective, more informed, and sensitive to a wide range of ethical considerations. Worse approaches leave out significant factors.

¹ Chris MacDonald, *et al*, “Charitable Conflicts of Interest,” *Journal of Business Ethics* 39: 67–74, 2002. p. 68.

Presented below are two different models of ethical decision-making. Either or both might profitably be applied to any given real or hypothetical situation.

A Principle-Based Model

A principle-based model seeks to identify a number of key ethical principles – general statements about how we should behave – that need to be considered in making an ethical decision. These principles serve as a focus for ethical consideration. The process is left more or less vague: what is important is that these key principles all be at least considered. The idea is that if you have given due consideration to each of these core principles, you are unlikely to have left unexamined any major ethical facet of the case.

The most famous principle-based approach in modern health-care ethics is the 4-principle approach advocated by Tom Beauchamp and James Childress in their book, *Principles of Biomedical Ethics*. The four principles identified by Beauchamp and Childress are Respect for Autonomy, Nonmaleficence, Beneficence, and Justice.

- *Respect for Autonomy*: Autonomy is the right that competent persons have to make decisions about their own lives, and, in particular, about their own health care. Respecting autonomy means respecting the right of a patient to determine, within the boundaries of good clinical practice, the course of their treatment. It involves acknowledging that while you are the expert on optometry, the

patient is the expert on what he or she *wants*.

- *Nonmaleficence*: Nonmaleficence – the principle that enjoins us to avoid doing harm – is perhaps the oldest ethical principle of the health professions.
- *Beneficence*: Beneficence, or the principle that requires us to help when we can, is the principle that health professionals most readily recognize as central to their practices. The key, here, is to remember that the demands of respect for autonomy means that health professionals must think of beneficence in terms of what the *patient* will see as beneficial.
- *Justice*: Justice requires the fair and equitable distribution of benefits and burdens. In the context of health services, questions of justice often arise at the level of public policy (how should various health services be funded?) But justice is also an issue at the level of clinical practice. For example, all clinicians must decide what is a fair and equitable way to divide a limited amount of time and attention among various patients in need. Also, justice arises in the demand that we treat all patients as equals, regardless of gender, race, sexual orientation, etc.

A Process-Based Model

A process-based model describes a suitable process or *procedure* to guide you through the process of ethical decision-making. Such a model leaves it to you to fill in

the relevant principles or values, based, for example, on the principles and values embodied in your professional Code of Ethics.

What follows is a process-based model, based upon one developed by the author and revised over a period of several years. The generic version of this process is available on-line at <http://www.ethicsweb.ca/guide/>

The steps outlined here should serve as a guide. The ordering of the steps is not crucial, and might well vary depending upon the situation.

A. Recognize the Moral Dimension

- The first step is recognizing the decision as one that has moral importance. Important clues include conflicts between two or more values or ideals.

B. Identifying Interested Parties & their Relationships

- Carefully identify who has a stake in the decision. In this regard, be imaginative and sympathetic. Often there are more parties whose interests should be taken into consideration than is immediately obvious.
- Look at the *relationships* between the parties. Look at their relationships with yourself and with each other, and with relevant institutions. Do those relationships bring special obligations or expectations?

C. Identifying the Relevant Principles or Values

- Think through the shared values that are at stake in making this decision. Is there a question of *trust*? Is personal *autonomy* a

consideration? Is there a question of *fairness*? Is anyone to be *harmed* or *helped*?

D. Weighing the Benefits and the Burdens

- Benefits – broadly defined – might include such things as the production of goods (physical, emotional, financial, social, etc.) for various parties, the satisfaction of preferences, and acting in accordance with various relevant values (such as fairness).
- Burdens might include causing physical or emotional pain to various parties, imposing financial costs, and ignoring relevant values.

E. Looking for Analogous Cases

- Can you think of other similar cases, either from your own clinical experience or from the anecdotes and “war stories” of your colleagues? What course of action was taken? Was it a good decision? How is the present case like that one? How is it different?

F. Discussing with Relevant Others

- The merits of discussion should not be underestimated. Time permitting, discuss your decision with as many persons as have a stake in it. Gather opinions, and ask for the reasons behind those opinions. Remember that your ability to discuss with others may be limited by the obligation to guard patient confidentiality.

G. Does this Decision Accord with Legal and Organizational Rules?

- Some decisions are appropriately made based on legal considerations. If one of the available options is illegal, we should at least think very seriously before taking that option.
- Decisions should also be made in light of the requirements of your Codes of Ethics that are intended to guide individual decision-making. Institutions (hospitals, banks, corporations, insurance agencies) may also have policies that limit the options available to you as a clinician.
- Sometimes there are bad laws, or bad rules, and sometimes those should be broken. But too often we do so in bad faith, and engage in short-sighted, self-serving rationalization. *Usually* it is ethically important to pay attention to laws and rules.

H. Am I Comfortable with this Decision?

- Sometimes your 'gut reaction' will tell you if you've missed an ethically significant aspect of the situation.
- Questions to ask yourself include:
 - 1) If I carry out this decision, would I be comfortable telling my family about it? My clergyman? My clinical instructors and mentors?
 - 2) Would I want children – or my students and trainees – to take my behaviour as an example?
 - 3) Is this decision one that a wise, informed, virtuous person would make?

4) Can I live with this decision?

Conclusion

Neither this process nor any other can guarantee that you will make the right ethical decision. Your goal, as a professional, should be to approach such issues attentively, to learn from experience, and to be able to give thoughtful answers when the reasoning behind your decisions is challenged.

Appendix: Resources for Further Study

Print Resources:

Books on Professional ethics in general:

- *The Ground of Professional Ethics*, by Daryl Koehn (Routledge, 1994)
- *Case Studies in Allied Health Ethics*, by Robert Veatch *et al* (Pearson, 1997)
- *Meaningful Work: Rethinking Professional Ethics*, by Mike W. Martin (Oxford University Press, 2000)

Books on medical ethics and health-care ethics:

- *Principles of Biomedical Ethics*, 5th Edn., by Tom Beauchamp and James Childress (Oxford University Press, 2001)
- *Doing Right: A Practical Guide to Ethics for Medical Trainees and Physicians*, by Philip Hébert (Oxford University Press, 1996)
- *Clinical Ethics: A Practical Approach to Ethical Decisions in Clinical Medicine*, 4th Edn., by

Albert R. Jonsen *et al* (McGraw-Hill, 1997)

Internet-Based Resources:

ProfessionalEthics.ca

<http://www.professionaethics.ca>

The EthicsWeb Bookstore
<http://www.ethicsweb.ca/books> (the
 world's largest ethics bookstore)

"A Guide to Moral Decision-Making," by
 Chris MacDonald, Ph.D.
<http://www.ethicsweb.ca/guide/>

Sample Case Discussions

Following are seven cases. Cases of the sort examined here seldom present the possibility of a single, unambiguous, correct answer. Further, as Caroline Whitbeck argues, ethical problems seldom require that we choose between well-defined options. They more often require that we design responsible courses of action, and update those designs as things proceed.² You are challenged to read the cases and respond to the questions that follow each case.

If you choose to participate in this home study continuing education program, you should complete the answer sheet and return it to the College along with your cheque for \$101.70 (\$90 + HST). For out of province participants, the cost is \$113.00 (\$100 + HST). Upon receipt at the College, you will be provided with

² Whitbeck, Caroline. 1996. "Ethics as design: Doing justice to moral problems." *Hastings Center Report* (May/June):9-16.

additional analysis of the cases, and comment on the answers. The College will issue a continuing education certificate for 6 hours for your participation in this program.

Case #1: Confidentiality

Ashley, a 15-year-old long time patient, presents with complaints of a red right eye with discharge of 6 weeks duration. She has seen her family doctor twice and has had no improvement in symptoms despite two courses of topical antibiotics. Slit lamp examination reveals a mixed papillary and follicular response with superior SPK and sub-epithelial infiltrates. There is a palpable preauricular node. Your working diagnosis is Chlamydial Inclusion Keratoconjunctivitis. With great delicacy you ask Ashley about sexual activity and recent vaginal or urinary tract infections. She admits to both. You explain your suspicions and the implications for her and her partners. Ashley becomes visibly distraught. You know that her mother, also a long time patient, is in the waiting room. You suggest that her mother comes in to the examination room to discuss your suspicions and referral to her GP for appropriate tests and treatment. This seems to upset Ashley further. She asks you not to talk to her mother and states she will not seek treatment. It is clear Ashley's mother does not realize her daughter is sexually active and Ashley is anxious about her reaction. Despite your attempts to persuade her, Ashley will not give her consent to release information to her mother or her physician.

Question 1: Which of the following best describes your obligations in this situation?

- a) My main obligation is to respect Ashley's privacy. I should express my concerns to Ashley as clearly as possible, making clear to her that Chlamydia is a serious STD, and send her on her way.
 - b) Chlamydia is a reportable disease under the *Health Protection and Promotion Act*. I should therefore inform Ashley that I will have to discuss the situation with her mother.
 - c) Since Chlamydia is a reportable disease under the *Health Protection and Promotion Act*, I should inform Ashley that, were I certain that she had Chlamydia, I would be legally required to report her name to the Medical Officer of Health. I should strongly encourage Ashley to visit her physician as soon as possible, but I should also respect her wish for privacy.
 - d) As a minor, Ashley is considered too young to make serious health-related decisions on her own. I should inform Ashley's mother as tactfully as possible, taking what measures I can to preserve the patient's dignity and to preserve the clinical relationship.
- c) Ashley's privacy, and the need to maintain her confidence in the clinical relationship, is paramount. I should drop the subject, and make no note of the Chlamydia in Ashley's chart.
 - d) Ashley's privacy, while important, is partly outweighed by considerations of public interest. If this were a confirmed case of Chlamydia, reporting Ashley to the Medical Officer of Health would be appropriate, and not considered a violation of my duty of confidentiality. In light of my suspicions, I should strongly encourage Ashley to see her physician about this issue. Ashley does have a right, however, to keep this issue from her mother.

Question 2: Which of the following best describes the relevant privacy considerations in this case?

- a) Ashley's privacy, while important, is outweighed by her mother's right to know what is wrong with her daughter.
- b) Ashley's privacy, while important, is outweighed both by her mother's right to know and by my professional obligation, under the *Health Protection and Promotion Act*, to report cases of Chlamydia.

Question 3: When is a patient considered competent to refuse treatment or other intervention?

- a) Any competent adult (i.e., over 18) may rightly refuse any and all interventions.
- b) Age, in and of itself, is not the relevant factor in determining competency to make health-related decisions. All patients are presumed competent, in the absence of specific indications of incompetence.
- c) Young patients should be increasingly involved in decision-making as they get older. Teenage patients should be involved to a significant degree, but parental consent is still required prior to age 18.
- d) The wishes of any patient who shows no signs of mental defect should be respected. However, Ashley's refusal to acknowledge the seriousness of this situation

suggests that her emotional state has rendered her effectively incompetent. Given this fact, her wishes may safely be overridden.

Case #2: Conflict of Interest

Dr. Member has been having difficulty maintaining a profitable practice because of high operating costs. He is approached by the regional representative of a national fully-integrated optical firm which owns and operates vision centres for the dispensing of designer eyewear as well as providing a full range of contact lenses and eyecare products in its manufacturing division.

The firm is opening a new full service vision centre in the area and they would like Dr. Member to participate as the resident optometrist. The firm will provide office space adjacent to the new Vision Centre at a rate that is 75% of his current arrangement as well as provide office equipment at reduced lease rates. Dr. Member must sign a long-term contract to remain at the location and agree to a verbal arrangement to purchase and prescribe all vision products from a related division. This would create a one stop shopping arrangement for the patient.

In order to assist Dr. Member in managing his practice, the Vision Centre will provide Dr. Member with database software linked to the firm's network to manage patient bookings. The neighbouring dispensary will also have access to the program to allow their staff to book patients for eye exams for their customers through the shared network. In return, the dispensary will receive an administration fee of \$5.00 for each patient booking they make. This will

reduce the administrative staff requirements for Dr. Member. The firm also plans to use the database to send patients promotional material periodically throughout the year. In order to protect privacy, no outside staff will have access to any patient's medical history.

In addition, Dr. Member will be provided with a pre-numbered book of gift certificates providing all patients a \$25 discount off the cost of glasses from the Vision Centre's dispensary. For each gift certificate used by a patient, Dr. Member will receive a commission of \$10. This will more than compensate Dr. Member for the \$5 administration fee for any patient bookings made by the Vision Centre. The company has also instituted a promotional campaign for all optometrists across Canada. The optometrist with the highest conversion rate will receive a deluxe vacation for two in the Caribbean. In order to avoid jealousy from other staff and patients, the company suggests that Dr. Member not publicize the existence of the promotional campaign.

Question 4: Does the arrangement proposed by the company in this case constitute a conflict of interest for Dr. Member?

- a) No. It's only a conflict of interest if the financial incentives being offered to Dr. Member are sufficiently large to influence his judgment. But the incentives offered here are relatively small; so there's little chance that patients' well-being is being jeopardized.
- b) Maybe. It depends on whether the arrangement proposed actually benefits Dr. Member's patients. If he can be sure that his patients

benefit, then there is in fact no conflict of interest.

- c) No. This isn't a case of conflict of interest because the arrangement is in everyone's interest: Dr. Member, the optical firm, and patients all benefit from this efficient way of providing care.
- d) Probably.

Question 5: What are the elements of a "textbook" conflict of interest?

- a) The four elements are 1) a set of obligations detailed in a code of ethics, 2) a professional duty to put the good of one's patients first, 3) an obligation to maintain the integrity of one's profession, and 4) a real or apparent conflict between 2) and 3).
- b) The three elements are 1) an official or professional duty, 2) a private or personal interest on the part of professional, and 3) the potential for (2) to interfere with judgment regarding (1).
- c) The four elements are 1) a professional obligation to one's patients, 2) a business relationship with some third party, 3) the receipt of non-standard financial rewards, and 4) clear indication that those financial rewards influenced the professional's judgment in ways that harmed patients.
- d) The three elements are 1) an official or professional duty, 2) a private or personal interest on the part of the professional, and 3) the potential for (1) to interfere with judgment regarding (2).

Question 6: If Dr. Member accepts the optical firm's offer, why might a patient

reasonably question Dr. Member's clinical judgment in future?

- a) Because the arrangement is financially advantageous to Dr. Member.
- b) Because the arrangement rewards Dr. Member for steering patients to this particular supplier of glasses, rather than to the supplier who can best meet the patient's needs.
- c) Because patients may not trust the optical firm involved as much as they trust Dr. Member.
- d) Because no optometrist can withstand the kinds of financial inducements being offered.

Case #3: Insurance

Mrs. I.C. Well has been a loyal patient for many years. Her vision is very good and ocular health is excellent. She strongly believes in preventive care and visits your office yearly. This year she presents without complaint and an examination is performed. You find no change in the refractive error. The remainder of the examination is unremarkable. You counsel her that her eyes are healthy and her vision is terrific.

At the end of the examination she mentions that she works at the local plastics factory as an inspector and qualifies for the vision care plan at work. Her coworker told her that if she had a change in the prescription she could get her glasses covered under her insurance plan. She asks you if you could write her a prescription even if it won't make a difference in her vision so she could get the glasses covered.

Question 7: Will anyone be harmed if the optometrist in this case issues the prescription that Mrs. Well wants?

- a) Yes. The insurance company will suffer financially, even if only a relatively small amount.
- b) No. This is a “victimless crime.” No one really stands to be hurt.
- c) Yes. The insurance company will suffer financially; and the costs it suffers are very likely to be passed along to the entire group covered. Mrs. Well also faces possible suspension of her coverage.
- d) No. The only potential harm is that Mrs. Well *might* face possible suspension of her coverage, if this “stretching” of the rules is discovered. But that is very unlikely.

Question 8: What is the best way to deal with a patient request of this sort?

- a) Issue the prescription the patient wants: it’s not the optometrist’s job to play referee between a patient and his/her insurance company.
- b) Issue the prescription the patient wants, but warn him/her that he/she may be engaging in insurance fraud.
- c) Refuse to issue the prescription, and terminate your clinical relationship with the patient.
- d) Refuse to issue the prescription, and explain the ethical and legal reasons to the best of your ability.

Question 9: What does professional autonomy imply, in a case like this?

- a) The fact that optometrists enjoy a degree of professional autonomy means that they may conduct their

clinical practices autonomously, without external constraints.

- b) The fact that optometrists have professional autonomy means that they are free to pursue whatever course of action is best for their patient.
- c) The fact that optometrists enjoy a degree of professional autonomy implies that she/he may act autonomously, guided by her/his own judgment and integrity.
- d) The fact that optometrists enjoy a degree of professional autonomy implies that they are free to practice according to the standards of their profession.

Case #4: Mandatory Reporting

A 60-year old man has been a long-term patient in your practice. He arranges an appointment for an oculo-visual assessment. Upon reviewing his clinical record you discover that his last assessment at your office was over 5 years ago. He has not attended any other practitioners since then. His occupation is unchanged as a travelling salesman who drives to service his clients within the province. He is the sole breadwinner for his family.

The case history does not reveal any remarkable health concerns. He complains of some difficulty with night driving. The internal examination shows the presence of an inactive maculopathy that is causing reduced visual acuity. Best-corrected acuity is below the legal limits for driving. All other vital ocular health information is unremarkable. There appears to be no active ocular pathology.

The optometrist decides to reassess the patient on a subsequent day to give him a second chance to determine if the corrected acuity can be improved. Unfortunately, the reassessment shows identical results as the prior exam.

The optometrist informs the patient of the relevant clinical information. The patient is advised that an ocular pathology over a 5-year period has caused an irreversible reduction in best-corrected acuity; that the present acuity does not meet the minimum visual standards for driving; and the optometrist will have to send his findings to the Ministry of Transportation.

The patient becomes emotional and pleads with the optometrist to help him. He goes on to state that if he cannot drive he will lose his job. He further states that if he loses his job, his home will be in jeopardy due to the mortgage financing that exists.

Question 10: What is the best course of action in this case?

- a) The optometrist should inform the Ministry of Transportation of the patient's reduced acuity.
- b) The optometrist should modify the clinical record to show that the patient does meet the vision requirements for driving.
- c) The optometrist should do nothing: he/she should neither inform the Ministry, nor alter the clinical record.
- d) The optometrist should inform the patient that it is unethical to drive with impaired vision, and strongly recommend that he turn in his driver's licence.

Question 11: Should the optometrist at least consider making an exception to the rules in this case, in consideration of this patient's special circumstances?

- a) Yes. This is the sort of difficult situation that most clearly calls for professional judgment and discretion.
- b) No. It is not the optometrist's place to make judgments about individual need in cases like this.
- c) Yes. This case requires a judgment about visual acuity, and that is well within the expertise of the optometrist.
- d) No. Optometrists should never make judgments that weigh the good of one human being against another.

Case #5: Personal Relationships with Patients

John Smith graduated from Optometry School and moved back to a somewhat remote area in Northern Ontario. He had been raised in this region and decided to return to the area for his professional career as there was a genuine need for vision care in this remote location. Although he established a practice in a town 50 km. from his home village, he had a very large drawing area as the next nearest optometrist was about 100 km. away. Naturally, many of the local population knew of him from his formative years and were eager to consult him about their vision problems.

While attending high school, John had a number of girlfriends, many of whom were still living in the area. He had been popular at University and had a number of semi-serious relationships, however chose not to pursue any long-term commitments at the time.

Once he had returned, he started into a social pattern typical of the area, playing sports and spending most of his leisure time with a group of young men in his age bracket. While attending a party for his baseball team, he met up with a woman named Lisa whom he had known in high school. He had recently examined her eyes as a patient and she had expressed interest in obtaining contact lenses. They had dated a few times previously and it soon became apparent that they were again mutually attracted. John vaguely remembered a lecture about ethical principals involving relationships with patients, but he reasoned that this woman was an old high school friend and wasn't just "any patient". Furthermore, in this rural area, virtually every woman of his age was a patient in his office, and it wasn't practical to go to other towns or cities to look for companionship.

They went out on dates a few times and saw each other with increasing frequency. John fitted her with the newest continuous wear contact lenses and performed all the related services at no charge. He became well acquainted with her parents, who also were patients, and extended them services at no charge.

John and Lisa decided to cohabitate, but shortly thereafter their relationship started to change. John noticed that Lisa was not content with continuing their lifestyle as singles and therefore decided to leave, despite her protests. It unfortunately was not an amicable parting, and a great deal of ill will was generated between Lisa and her family and John.

About two weeks after they separated, Lisa developed some minor symptoms of

ocular irritation, but decided not to see John about them. The minor symptoms developed into a serious eye infection and she consulted her medical doctor. She was referred to an ophthalmologist in a city about 1 hour away who diagnosed a central corneal ulcer. Despite aggressive treatment, she was left with a corneal scar and reduced vision in the eye.

Lisa complained to the College of Optometrists and also initiated a civil action against John for failing to maintain proper standards of care. Although John had performed the usual and necessary services for her clinical treatment, he neglected to obtain her informed consent in writing, as he normally would do with patients. She had hesitated seeking care when symptoms first arose, due to their strained personal relationship.

Question 12: Was the optometrist in this case in violation of Ontario's *Regulated Health Professional Act*?

- a) Yes. The optometrist was in violation of the *Act*.
- b) Yes. The optometrist was in violation because he provided free services in the context of a personal, romantic relationship.
- c) No...he wasn't in violation of the *Act*, because the *Act* merely forbids health professionals from beginning a new relationship with someone who is already a patient.
- d) No...the *Act* provides an exception for health professionals working in isolated rural settings.

Question 13: Restrictions on romantic relationships between health professionals and patients are best described as...?

- a) Outdated, Victorian prudishness, imposing unnecessary limits on adult sexuality and romance.

- b) Outdated professional standards originally intended to protect health professionals from accusations of “scandalous” behaviour.
- c) An unfortunate, but necessary, limit on the freedom of competent adults.
- d) An unfair restriction imposed by society upon health professionals.

Question 14: When you find yourself romantically attracted to a patient, what should you do?

- a) Continue providing care until you are sure the relationship is serious, and then proceed with caution.
- c) Broach the topic tactfully with the patient. If the feeling is reciprocated, and if the patient understands that a dual relationship may present some complications, only then should you begin a romance.
- c) With the patient’s agreement, transfer the patient to another optometrist, and only then proceed to initiate a relationship.
- d) It is best to avoid such relationships altogether.

Case #6: Third Party Insurance

Denise presented for her oculo-visual assessment on September 10, 2002. It was determined that a change in prescription was necessary and she looked forward to updating her glasses.

After spending many hours in the dispensary and consulting with various girlfriends, a suitable flattering frame was chosen and the glasses were ordered that day. These were dispensed to her a week later.

Denise’s vision care plan allows for a \$200 claim for spectacles every 2 years. As her previous oculo-visual assessment was more than 2 years ago, she assumed that she was now entitled to claim and Denise submitted her receipt for the \$260 she had paid for her spectacles. She had forgotten that although her previous assessment was in August 2000, due to her very busy lifestyle, she hadn’t got around to choosing and ordering her glasses until November of that year.

The insurance company refused her claim on the basis that it was less than 2 years since her previous claim.

Denise called the insurance company to tell them that if she had realized she would have waited until November to order and asked if there was anything that they could do as she was counting on that money to add to her holiday fund. She was advised to return to her optometrist and get them to reissue the receipt with a new date that would allow her claim to be processed.

The optometrist has been previously informed by the College and by insurance companies that this would constitute insurance fraud. Denise asked the practitioner to call the insurance company to verify the advice she was given.

When the optometrist called the insurance company, they were told that ‘to get around the problem’ they should either reissue the receipt with an appropriate date or if they didn’t feel comfortable with that, give the patient a refund, take back the spectacles and ‘re-dispense’ them to the patient at the appropriate date. The patient was told that if the practitioner wouldn’t comply it was because of the ‘practitioner’s personal office policy’ and had nothing to do with the insurance company.

The optometrist then contacted the Insurance Bureau of Canada for clarification. They re-confirmed that they would consider it insurance fraud if a new receipt was issued.

Question 15: What is the best course of action for the optometrist in this case?

- a) Re-issue the prescription.
- b) Re-issue the prescription, and note the insurance company's instructions in the patient's chart.
- c) Refuse to re-issue the prescription.
- d) Refuse to re-issue the prescription, and consider advocating, either on her own or through her professional body, for improvements in the system.

Question 16: Is it ever ethically okay to work to "get around" an insurance company's policies?

- a) Yes; the optometrist's job is to look after the needs of patients, not the needs of insurance companies.
- b) Yes. It is ethically O.K. – even ethically required – for an optometrist to work around an insurance company's policies if those policies are unfair.
- c) No. Working to "get around" an insurance company's policies is illegal.
- d) No. An optometrist has neither the expertise nor the authority to determine which insurance company policies are "unfair."

Case #7: Treating Family Members

Dr. Familyman examined his mother's eyes yesterday during which he found intraocular pressure readings of OD 25mmHg and OS 28mmHg. He has examined her eyes every year since

graduating in 1985 and has always found pressures in the 18 to 20 range and cupping at the optic nerve of 0.5 in each eye. The optic nerve remains unchanged. The high pressure reading made him tense as he knows his mother over reacts to any hint of a health problem.

Dr. Familyman explained that the high pressure reading is an indication for more investigation and recommended a field test that he booked for the next day in the morning. Mrs. Familyman Sr. was very quiet in the office and left without asking questions but called her son that night in tears with worry over the possibility of glaucoma.

Later in the afternoon Dr. Familyman saw a new patient, 58-year-old Mr. Truckdriver, who had not had an eye exam for 12 years. He found intraocular pressures of OD 34mmHg and OS 31mmHg. The cupping at the optic nerves was 0.7 OD and 0.6 OS with very suspicious inferior rim tissue OD. Visual fields were run that day and revealed a superior relative arcuate defect OD. Dr. Familyman is sure Mr. Truckdriver has primary open angle glaucoma and had his receptionist call the glaucoma specialist for a referral appointment. The earliest she can see him is 6 months away.

Although Mrs. Familyman Sr. tried very hard, the field tests were not very reliable and repeat pressures were OD 27mmhg and OS 29mmhg. She tearfully asked for a referral to the glaucoma specialist she has heard her son speak highly of and he agreed it is probably better if someone else manages his mother. Dr. Familyman makes the call himself and is offered an appointment the next day to fill a cancellation. He is very conflicted since he knows Mr. Truckdriver should have

tomorrow's appointment but he also knows he will hear of little else for the next 6 months if his mother has to wait.

Question 17: Ethically, how should Dr. Familyman allocate his resources (in this case, his time)?

- a) He should allocate his time according to the patients' degree of need.
- b) "Blood is thicker than water." He should give priority to his mother.
- c) "First come, first served." He should allocate his time according to the order in which he became aware of the 2 patients' needs.
- d) Since values such as need, urgency, and family obligations conflict, there is no right answer. Dr. Familyman should flip a coin.

Question 18: Should Dr. Familyman have *avoided* treating his mother in the first place?

- a) Yes. It is always considered a conflict of interest to treat family members.
- b) No. As a good son, Dr. Familyman is obligated to care for his mother.
- c) Yes. It is generally wise to avoid providing non-emergency treatment to family members.
- d) No. It's fine to treat family members, so long as they are not given preferential treatment over others.

Professionalism and Professional Ethics

Professionalism and Professional Ethics is a distance education module prepared for the College of Optometrists. If you want to participate in this home study continuing education program, you should complete the answer sheet below by circling the most appropriate answer, and return your completed answer sheet to the College along with your cheque (made out to the College of Optometrists of Ontario) for \$101.70 (\$90 + HST). For out of province participants, the cost is \$113.00 (\$100 + HST). Upon receipt at the College, you will be provided with additional analysis of the cases, and comment on the answers. The College will issue a continuing education certificate for 6 hours for your participation in this program.

Name: _____

Address: _____

Question 1. A B C D

Question 2. A B C D

Question 3. A B C D

Question 4. A B C D

Question 5. A B C D

Question 6. A B C D

Question 7. A B C D

Question 8. A B C D

Question 9. A B C D

Question 10. A B C D

Question 11. A B C D

Question 12. A B C D

Question 13. A B C D

Question 14. A B C D

Question 15. A B C D

Question 16. A B C D

Question 17. A B C D

Question 18. A B C D