ETHICS IN VISION THERAPY

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Abstract

The fundamentals of ethics (beneficence, nonmaleficence, autonomy, and justice) apply to all health care providers, including optometrists. These basic elements must articulate with the behaviors associated with ethical practitioners, including competence, truth telling and confidentiality. The specialties within optometry, such as vision therapy, are sometimes subjected to specific ethical dilemmas. These have been exacerbated within the contemporary health care environment. In this paper the author discusses some of the ethical issues that impact upon this treatment mode.

Key Words

vision therapy, beneficence, nonmaleficence, autonomy, justice, confidentiality, veracity, competence, third party payers

Vision therapy, as with all health care services, needs to be sensitive to the generic bioethics criteria. There are no exclusive guidelines assigned to this treatment modality, nor should there be. This means that the practitioner must employ the same ethical litmus tests with vision therapy as with all health care decisions. However, differing types of patient care decisions sometimes create specific ethical dilemmas.

Background - Ethics

Ethics is a moral concept often measured by behaviors.[1] Ethical behavior is usually internally generated by a person or group of persons in the same community, discipline or organization. This differs from law, which is created by society. Professional ethics is different from ordinary morality because the nature of the profession dictates the ethical priorities. As an example, while professions in general have obligations to both the patient (or client) and society, the relative proportions of this moral obligation may vary with the profession. While the engineer may owe more to society than to the individual, the doctor's relative loyalty is usually the opposite.[2]

While the ethical practitioner is essentially law abiding, there are ethical issues that may sometimes be considered as superseding law. History has recorded many situations when one's ethical framework may contradict law. Some examples of this include, but are certainly not limited to, both sides of the abortion issue, physician-assisted suicides, genetic research, as well as exemplified in the lives and teachings of Gandhi and Dr. M. L. King.

Medicine traces its ethics origins to ancient Greece, although 2000 years passed before the Hippocratic Oath became officially integrated into medical ethics. The importance of ethical practice to optometry was evident when a committee chaired by Andrew J. Cross drafted the first Optometric Code of Ethics in 1908. This was only seven years after the first optometry law in Minnesota.[3] The year 1994 marked the 50th anniversary of the American Optometric Association's Code of Ethics. This code has been updated periodically by the inclusion of the Rules of Practice and the Optometric Oath.

Modern medical ethics originated in the early 1960s with the coalescence of the Patient's Rights Movement and medical technology, specifically kidney dialysis instrumentation.[4] The medical technology and information explosion, accompanied by increased successes with organ transplants, enabled physicians to enhance both the quality of life and life prolongation with previously terminal patients. Unfortunately this existed in a world with insufficient resources for universal access. The theoretical concept of the rationing of health care became a reality. In order to cope with these problems, hospitals created committees to tackle the difficult decisions which were essentially who shall live and who shall die. It is not surprising that they were referred to as "God Squads." Medicine, recognizing the full scope of problems involved with these decisions, brought non-physicians into the process. Therefore, "God Squads" were comprised of physicians and non-physicians. The discipline of medical ethicist grew from this concept. They and others

trained in ethics, usually physicians, theologians, and/or philosophers helped to shape a discipline with an organized structure and a literature, and evolved the critical thinking process necessary in contemporary medical ethics. Ethical decision making became more than just doing the right thing in this complex new world which also featured a changed doctor/patient relationship.

An additional player also entered the system: third party payers. They may be governmental agencies, insurance companies, professional alliances, or business entities. This group created further changes. Since they were paying for the care rendered and assumed some of the risks, they demanded a significant role in the process. The doctor, appreciating the more recent rules of practice with patients playing a larger role in their personal medical care decisions (autonomy), now also had to relate and satisfy the requirements of this other entity. The third party payers exercise their influence on the doctor by indicating the tests, treatments, and procedures they will reimburse, at what frequency, and for which conditions. In addition they have created a reimbursement scale influenced by many factors, including the competitive profit-driven marketplace in which they have to sell health services to purchasers. This new managed care marketplace now drives all aspects of the system, including the level of care.[5] The frustration of the practitioner is additionally heightened because these groups are not as susceptible to political, legal, or other pressures as were governmental agencies in the past. Doctors may elect to join or create provider panels, but as a participant, must accept the rules and payment scales dictated by these groups. Some doctors may also find themselves excluded from joining and have little recourse since these groups are not subject to some of the restrictive legislation of the past.

The recognition that complex ethical decision making is now a integral part of all health care stimulated virtually every health professional program to teach ethics.[6] The fundamental elements of "medical" ethics—autonomy (patient rights), justice (fairness), beneficence (do good) and nonmaleficence (do no harm)—have been expanded in the behavioral definition of the ethical doctor who is truthful, competent, maintains confidentiality, has integrity, and always considers the patient's interests as primary. These elements must then be integrated into this complex new health care world.

The Ethical Dilemmas in Vision Therapy

As mentioned earlier, in general most optometric ethical decision making is generic regardless of the specific area of care. However, there are some ethical issues somewhat idiosyncratic to vision therapy or where this therapy places an additional "spin" on the issue.

1. Competence

   The first element that needs to be addressed is practitioner competence. Jonsen defines competence as the primary virtue of the practitioner.[7] Clearly this universal issue is not unique to vision therapy or optometry. The primary care optometrist should demonstrate a recognized level of competence within the entire professional scope of practice whether he/she provides the services or refers to others. The vision therapy doctor who is not current and knowledgeable of all of the appropriate literature is as much at fault as the doctor who dismisses this treatment option out of hand for lack of knowledge.

   Competence should be reflected beyond the skills and knowledge of the doctor and extends to all of the ancillary staff who are delegated responsibility. This speaks to the training and knowledge of these personnel. The competence of the setting is reflective of the utilization of instrumentation and techniques that are well proven by research documentation. Standards of care with well-defined patient outcomes have an important place in all phases of patient care.[8]

   Competence may also be demonstrated with a credentialing process. The existence of the American Academy Diplomate in Binocular Vision, as well as Fellowship in the College of Optometrists in Vision Development, indicates that the vision therapy discipline is well aware of the importance of assessing the doctor's skills and knowledge.

2. Autonomy

   The optometrist has traditionally been accustomed to discussing the merits of this therapy with the patient (or a surrogate). Even with the absence of a formalized consent form, some informed consent was present. The absence of a consent form is not a criticism since its utilization in health care is a more recent phenomenon and it is more frequently employed when there is a greater risk of harm. Finkelstein[9] states that the potential risk and the community standard influences the need for written consent. Most dentists do not utilize such a form when providing basic care procedures nor do most physicians when drawing blood. However, consent must be present and the patient is entitled to an explanation of the needs, goals, and methods to be employed and should be aware that he/she can refuse a doctor's recommendation without prejudice.[10] Optometrists should be very comfortable discussing the risks associated with most vision therapy since the risks of the treatment are minimal. The doctor should also indicate the potential risk involved with the refusal to have this clinical intervention. True consent requires an understanding of the risks, benefits and costs without coercion. Patients must also understand their right to withdraw from therapy at any time. Most experts believe that the principle element in patient consent is patient understanding and the practitioner must be very certain that everything is understood and that information is presented under conditions that will enhance understanding.[11]

3. Reimbursement Dilemmas

   The ethical question, "How would I want to be treated if I were the patient?" is not as straight forward in today's world as in the past. A conflict may arise when there is a difference between the doctor's opinion of what is best for the patient and the payer's rules. These groups set the standards under which they will pay. Sometimes they employ consultants and if they have negative opinions concerning the value of vision therapy in general, or disagree in the treatment program, this can be problematic. Their acceptance (and payment) may be predicated upon specific diagnoses with proscribed treatment guidelines. The practitioner joining a panel or group should understand that these limita-

tions exist and know the process in place to adjudicate differences in professional opinion.

The doctor may be caught in a dilemma of indicating a less accurate diagnosis which will allow for patient reimbursement or risk that self-paying will discourage the patient from the desirable care. The concept of "How would I want to be treated" is tested in this situation. Would I prefer that my doctor be scrupulously honest and have to either pay out of my pocket or forego the care, or be reimbursed on the basis of a "massaged" diagnosis? It is easier to sit in judgment of the doctor caught in this dilemma than to be the doctor who is faced with the problem. While some practitioners may have a somewhat benign attitude about such situations, the insurance companies like to refer to this by the more provocative term "provider fraud." The motive for this term is obvious. Although insurance leaders have indicated that this is a common occurrence, the literature is devoid of any mention relating to optometric fraud.

Many of us remember that there was a time when our patients paid for all services, including vision therapy. In today's climate many people who have become accustomed to reimbursement may be very resistant to self-payment. These situations will require a significant patient reeducation process. The enlightened patient will understand when there is a conflict between the doctor's professional judgment and the rules of the payer.

4. Confidentiality

   The existence of quality assurance programs and peer review, as well as greater distribution of patient data in the managed care setting, has the potential to compromise confidentiality. Exchange of patient data (with waivers) between doctors now may include others in the loop. Ethics experts are beginning to discuss this issue with greater frequency, but simplistic solutions are not always available. At this time the best advice for the practitioner is to be aware when the confidentiality guidelines are at risk and to take whatever actions necessary to reduce the exposure. We are as yet unaware of all the implications (legal and otherwise) to either the doctor or the patients when confidentiality is breached during quality assurance or other documentation processes.

   At the very least, patients need to be informed how the information gathered during the examination may be disseminated.

5. Justice

   The concept of justice requires that each patient be treated fairly. Vision therapy is not only for middle class children. Some doctors have neglected others because of age or ethnicity—"They are too old, don't comply, break appointments, etc." Learning can take place at all ages and in many ways. It is wrong when rationing of care is inadvertently established along these lines. All patients must be treated as individuals and treatment options should be honestly addressed for their acceptance or rejection.

   In order to provide necessary care to the atypical vision therapy patient we may have to modify the process. The busy middle-aged attorney might agree to care if given the choice and if the office and treatment rooms are not obviously pediatric. Some others, with severe time restraints, might be amenable to receive needed care but it may require some creativity on the part of the doctor. With some, there may be a greater need for more home training in the process; in other situations other approaches can make vision therapy available. Unfortunately this can be additionally complicated with third parties who have reimbursement policies that conflict with more creative care. In these cases the self-paying patient may be easier to treat. Sometimes we become so enmeshed in how we typically (and successfully) manage patients that we forget that an alternate process may be possible. Optometry is moving away from the lock- step approach to our routine examination and the vision therapy provider must also consider the customizing of care, using flexible treatment options.

   An example of patients who are frequently inadvertently deprived of vision therapy services are head trauma patients. Too few of our own colleagues, and others in the health care establishment, are aware that patients with head trauma or who have had neurological accidents may be helped with vision therapy. As a profession we need to improve our "marketing" so that all of those patients who can benefit will be properly informed.[12] The patient will not be given the choice unless the doctor considers it as a treatment option. When this option is not considered, the concepts of autonomy and justice may be compromised.

6. Beneficence (Do Good) and Nonmaleficence (Do No Harm)

   These ethical principles have always been fundamental in health care. The recommendation of vision therapy should be predicated on our desire to help the patient. A good rule for the primary doctor to follow prior to recommending any service or procedure is, "If I did not perform this procedure, would I refer this patient?" In addition, one should ask, "Am I referring to the most qualified doctor to perform this service?" This may be additionally complicated by the existence of a panel which limits the selection process.

   The concept of harm must be extended beyond the physical harm to the patient, which, as mentioned earlier, is quite rare. One can do harm with the problems that training visits may create with the patient or the patient family's time and convenience. Harm can also be identified if the process is prolonged beyond the time of measured success. Concerned practitioners must be sensitive to these issues. We cause harm any time we do not respect the patient's time.

Conclusion

As with many discussions relating to ethics, we tend to raise more questions than provide solutions. Our purpose is to make the practitioner more aware of the issues involved and allow him/her to draw upon a previous ethical framework established from family, religion, education, and community and act for the betterment of the patient. Regardless of how the patient was directed to your care, who pays and how much, the practitioner still should be motivated by doing what is best for the patient. Every patient we accept is entitled to this both morally and legally.

The basic ethical dilemma of altruism versus self-interest is present in many of

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our clinical decisions.[13] We have joined a profession that is dedicated to helping people because of our altruism. However, there are fiscal considerations that need to be addressed. Self-interest need not be selfishness. In the vision therapy arena, as with the other aspects of the care we render, we must try to balance this conflict so that we can maximize the level of care available to our patients and be appropriately rewarded for these efforts. If we treat patients as we would wish ourselves treated, we will most often practice ethically.

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