SECTION

5

# PRACTICE ADMINISTRATION

# Ethics in Optometric Practice

CHAPTER 22

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*The White House Fence*
*Three contractors are bidding to fix a broken fence at the White House in DC. All three go with a White House official to examine the fence.*
*The first contractor takes out a tape measure and does some measuring, then works some figures with a pencil. "Well," he says, "I figure the job will run about $900: $400 for materials, $400 for my crew and $100 profit for me."*
*The second contractor also does some measuring and figuring, then says, "I can do this job for $700: $300 for materials, $300 for my crew and $100 profit for me."*
*The third contractor doesn't measure or figure, but leans over to the White House official and whispers, "$2,700." The official, incredulous, says, "You didn't even measure like the other guys! How did you come up with such a high figure?"*
*This last contractor whispers back, "$1,000 for me, $1,000 for you, and we hire the second guy to fix the fence." "Done!" replies the government official. And that, my friends, is how government contracting works!*

The goal of this chapter is to sensitize the reader to the probability that ethical considerations will arise in the management of an optometric practice. The words on these pages are not intended to instruct on the right choice to be made in any specific situation; rather, it is hoped the discussion will assist the reader in making sound decisions when faced with ethical issues in the business aspects of practice. The application of ethics in most any endeavor of life refers to the decision making surrounding choices to be made when values and standards related to duty, responsibility, and right and wrong behavior come into conflict.

To illustrate the unique nature of an optometric practice in relation to other businesses, the authors will refer to some theoretical precepts of business and economics. If we were to assume that operating an optometric practice was no different in principle than operating any other business selling goods and services in the marketplace, we would simply say that optometry has products and services to sell to those willing and able to buy. Business ethics typically demands little more of the business person than not coercing, cheating, or defrauding the purchasers of goods and services. This level of business ethics does not recognize that optometrists hold other obligations because they are members of a health profession. A professional code of ethics offers an alternative to the typical business philosophy of "caveat emptor," or "let the buyer beware."

Some may consider the business model for ethics as sufficient for optometry; however, optometry, like other professions, has authority through the control of knowledge that is important to the welfare of the public. It is largely this power of knowledge that has led society to hold optometry and the other health professions to a higher standard of conduct in professional practice than would be required of the average commercial business. Optometry accepts its duty to protect those it serves and reflects this obligation through its code of ethics, oath, and other documents.

Some optometric practices operate along lines established for business enterprises such as advertising as a means to entice customers (instead of patients), displays of merchandise, mark-ups of materials instead of fees for service, office locations more favorable to commerce, and lower profits from professional services offset by sales of higher volumes of merchandise. An optometrist may practice ethically or unethically whether the practice is "professional" or "commercial." Some argue that a "professional" practice, by its very nature, is more conducive to good moral and ethical behavior. The authors believe that professional behavior is more a function of the ethical values and integrity of the individual practitioner rather than the practice setting.

This chapter is primarily concerned with the ethics of the business aspects of optometric practice, although it should be remembered that the goal of optometric practice is to deliver competent eye and vision care to those who seek the services of the optometric professional. Managing a practice in such a manner to achieve this goal is essential. Doctors of optometry receive ethical guidance in managing their practices and patient care from a number of sources, including the Code of Ethics of the American Optometric Association (AOA), The Optometric

Oath, and certain policy statements adopted by the House of Delegates of the AOA. In addition, the text, An *Optometrist's Guide to Clinical Ethics*, offers guidance on ethical obligations and issues in optometric patient care, as well as addressing several practice management questions that impact quality of care. An online continuing education course, *Ethical Issues in Contact Lens Practice*, was released on the AOA Website in the fall of 2008. This course offers guidance on the management of a number of ethical issues that frequently arise in contact lens practice. Occasional articles of ethical importance appear in optometric journals, as well as in other journals and publications. All of these tools assist the optometric profession in educating its members regarding expected professional behavior. One goal of this guidance is to encourage professionals to place the interests and welfare of those they serve above monetary considerations, personal pride, and personal convenience.

The AOA Code of Ethics remained essentially unchanged for over 60 years from 1944 until a new version was adopted by the House of Delegates of the AOA in June of 2007. The current 2007 version of the Code of Ethics is in Box 22-1. The Optometric Oath is in Box 22-2.

It should also be noted that while the ethical guidelines addressed by these documents were drafted by members of the optometric profession, they flow from the historical dialogue between members of the public and the health professions. A profession's code of ethics and other guiding documents are at best only partial descriptions of the profession's obligations to the public they serve. The individual practitioner's and professional group's duties exceed any such listing.

**BOX 22-1**

### Code of Ethics of the American Optometric Association

**IT SHALL BE THE IDEAL, RESOLVE, AND DUTY OF ALL OPTOMETRISTS:**

TO KEEP their patients' eye, vision, and general health paramount at all times;

TO RESPECT the rights and dignity of patients regarding their health care decisions;

TO ADVISE their patients whenever consultation with, or referral to another optometrist or other health professional is appropriate;

TO ENSURE confidentiality and privacy of patients' protected health and other personal information;

TO STRIVE to ensure that all persons have access to eye, vision, and general health care;

TO ADVANCE their professional knowledge and proficiency to maintain and expand competence to benefit their patients;

TO MAINTAIN their practices in accordance with professional health care standards;

TO PROMOTE ethical and cordial relationships with all members of the health care community;

TO RECOGNIZE their obligation to protect the health and welfare of society; and

TO CONDUCT themselves as exemplary citizens and professionals with honesty, integrity, fairness, kindness and compassion.

**BOX 22-2**

### The Optometric Oath

With full deliberation I freely and solemnly pledge that: I will practice the art and science of optometry faithfully and conscientiously, and to the fullest scope of my competence. I will uphold and honorably promote by example and action the highest standards, ethics and ideals of my chosen profession and the honor of the degree, Doctor of Optometry, which has been granted me.

I will provide professional care for those who seek my services, with concern, with compassion and with due regard for their human rights and dignity.

I will place the treatment of those who seek my care above personal gain and strive to see that none shall lack for proper care.

I will hold as privileged and inviolable all information entrusted to me in confidence by my patients.

I will advise my patients fully and honestly of all which may serve to restore, maintain or enhance their vision and general health.

I will strive continuously to broaden my knowledge and skills so that my patients may benefit from all new and efficacious means to enhance the care of human vision.

I will share information cordially and unselfishly with my fellow optometrists and other professionals for the benefit of patients and the advancement of human knowledge and welfare.

I will do my utmost to serve my community, my country and humankind as a citizen as well as an optometrist.

I hereby commit myself to be steadfast in the performance of this my solemn oath and obligation.

Originally drafted by Richard L. Hopping, O.D., a founder of the Association of Practice Management Educators. The Optometric Oath has been adopted by the Association of Schools and Colleges of Optometry, the American Optometric Student Association, and the American Optometric Association."

At the heart of this discussion of professional practice management is the differentiation between a "profession" and an "occupation." A profession is characterized by (1) a high level of education, which must be achieved at an institution of higher learning; (2) licensing laws that restrict professional practice to those who qualify educationally and through other standards; (3) legal controls on practice to protect the welfare of the public; (4) self-regulation established through a national organization that helps to promote relevant laws, accredit institutions of higher learning, and conduct the business of the profession; and (5) adherence to a self-imposed Code of Ethics enforced by the members of the profession. Professionalism thus is obedience to a demanding code of excellence.

When making practice management decisions, the greatest discomfort comes when the most ethical course of action to take in a given situation is not clear; that is, two or more mutually exclusive courses of action have equal or nearly equal compelling moral arguments creating a dilemma. To choose the course of action that fulfills one moral obligation prevents the decision maker from choosing a second course of action with an equal or nearly equal moral obligation.

In optometric practice, such ethical dilemmas are quite rare. Most daily decisions that reflect ethical values are made on autopilot, or, in other words, we apply values that have

become a part of our professional being without giving conscious thought to what we should do. When an ethical problem arises because there is a conflict between important values, an ethical analysis will likely reveal one value superseding the others in importance, thereby giving guidance for the most appropriate action. Keeping one's integrity in the forefront is essential in ethical decision making, whether within the domain of business, patient care, or personal matters. Many of the ethical principles in the Code of Ethics refer directly to patient care, whereas others reflect on obligations for the management of the optometric practice, even though they are supportive of patient care. These principles help guide the manner in which practitioners manage their practices (see Box 22-1).

The Optometric Oath is likewise supportive of high ideals for both patient care and practice management.

## BALANCING PROFESSIONAL AND BUSINESS INTERESTS

Balancing professional and business interests can be a challenge for any health professional operating in an environment in which the business aspects of the enterprise determine the practice's viability to continue providing professional services to the public. Business interests, which typically look for financial performance (measured by revenues, costs, and profits), sometimes come into conflict with professional interests, which reflect social obligations of the practice toward the individuals and groups associated with the practice (patients, employees, suppliers, creditors, and others). Some may be hurt or harmed in some way, while others receive benefits. Some will have their rights ignored as others will see their rights acknowledged. The question is how to find a balance between business interests and professional interests when faced with an ethical problem that raises questions about what is right, just, and fair.

This is a common issue when recommending that patients have a spare pair of glasses or contact lenses. How about a spare pair of sunglasses and perhaps another pair of reading glasses? At some point such recommendations become more a business decision than a quality of care decision. How many spares do patients really need and how many should you recommend?

**CASE 1**

*You see a new patient with the complaint that he has never been comfortable with the contact lenses prescribed by another optometrist. You discover that the lenses are wrong and do not fit properly. If you refit the patient, how do you explain his previous trouble? Knowing that his prior lenses could never have provided good vision and comfort, do you tell the patient about your findings and suggest he return his prior lenses for a partial refund, or do you say nothing, protecting the reputation of your mistaken colleague but letting the patient suffer the economic consequences?*

Health professionals, including optometrists, must compete with each other for business in the marketplace. This business atmosphere is what our society's commitment to a free enterprise economic system says is necessary to produce the highest quality of goods and services for the best price. Such an outcome is most likely to occur when the consumer has perfect knowledge when making choices from among products and services offered by a business. However, the very nature of the health professions and the services they provide makes it difficult at best, and impossible at worst, for the average patient to know enough to evaluate adequately the services and products being offered. This makes the patient vulnerable to the unscrupulous, as well as the incompetent. In an effort to protect the public, the government, through legislation and regulation, tries to limit improper business practices by health professionals. However, the professions are usually granted a high degree of autonomy by the government and society on the premise that only that profession has the knowledge and experience to regulate itself.

Through antitrust efforts beginning in the 1970s, the federal government tried to stimulate business competition within the professions to give the public more choices. This government intervention led to a legitimizing of behaviors that previously were seen by many as unprofessional conduct. During this period of heightened consumerism, many codes of ethics, board regulations, and similar documents appeared to infringe on the open conduct of acceptable competitive business practices. Government actions had a chilling effect on many professions' efforts to regulate their members' conduct. While it did not change its Code of Ethics, in 1976 the AOA did archive its more restrictive Supplements to the Code of Ethics and its Rules of Practice, replacing them with the Standards of Conduct. More recently, the AOA archived The Standards of Conduct as redundant to the Code of Ethics and The Optometric Oath, prompting debate about the Standards' scope and detail.

Balancing professional obligations with business needs can be a significant challenge. This challenge has only grown in health care as managed care, or maybe more appropriately described as managed competition, has driven third-party managers and payers to make choices that many believe impact negatively the quality of delivered health care.

Over the past several decades, the expenditures for health care have grown at a rate that exceeds growth in other sectors of the economy. This expansion of costs has not been due simply to abusive fiscal behavior by health care providers and organizations as some may suggest. Much of the increased cost of health care is related to public demand for access to advances in health care technology. In turn, much of this demand is associated with an aging population and the success of the new technologies in keeping chronically ill patients alive and in need of continuing health care. State and federal governments, as well as other stakeholders in our economic system, have become keenly aware of the tendency for health care expenditures to increase more rapidly than the inflation rate of the rest of the economy, and many have undertaken efforts to slow or reverse the trend.

When discussions by the federal government for major reform of the health care delivery system were set-aside in the early 1990s, the private sector intervened by rapidly expanding managed care plans. This expansion of private sector managed care plans resulted in lower premiums than previous premium charges for the more traditional major medical insurance plans. This movement into more restrictive managed care plans resulted in lower payments to health care providers for services provided. This action occurred at a time when the costs of delivering these same services were frequently increasing. In more recent years, the premiums charged for health insurance plans have once again undergone significant annual increases, with those insured being expected to cover a greater portion of the costs.

One effect of the trend toward managed care was a reduction in existing excesses in practice such as the billing for diagnostic tests that many considered not medically necessary. The elimination of most such behaviors occurred fairly early in this movement, within the first 2 or 3 years of the new managed care programs. However, once these excessive cost patterns were eliminated, the effects of managed care began to influence practice behavior in a potentially negative manner. For example, there has been a tendency to increase the number of patients seen per day to offset reduced per patient revenues. The result has been a reduction in the amount of time provided by many professionals to individual patients, and in many cases, paraprofessionals began assuming a greater role in the delivery of care. This shift of responsibilities to paraprofessionals is not automatically bad, but it happened very quickly and chiefly for financial reasons and not always with the increased education and supervised training that is needed. It has been argued by some in fact that optometry could more aptly serve the growing demand for eye and vision care while controlling costs by making better use of well-trained paraprofessionals. The common result, however, is less time and attention being provided by the best trained and most qualified provider. While many Americans may be willing to accept that trade-off to save costs, many health professionals initiated new practice activities to generate additional practice income apart from that provided by third-party payers.

Third-party payers for eye and vision care services then began a pattern that has been increasing in recent years. For years, optometrists were isolated from insurance reimbursement for professional services because the profession did not initially provide medical eye services and the vision care services they did provide were typically not covered. With the expansion of the scope of optometric services and the added provision of vision care in many insurance plans, the management of optometric practices is now greatly impacted by third-party payers.

One view of a profession is as a collective entity that appeals to society's representatives (state legislatures) with the promise that, if society will give the profession the privilege (license) to perform certain acts, they will use their special expertise for others' benefit, in competent and ethical ways. Once this privilege is granted, society trusts that individual members of the profession will act according to the agreement. If an individual practitioner violates the trust, it is not only the practitioner's patient but also the whole society and the entire profession that suffers. It is the collective pledge of the profession that makes it possible for people to trust the individual practitioner. Therefore the behavior of any one practitioner impacts the public's contract with and perception of the profession, and ideally, the profession should work to correct individual shortfalls from ethical practice. Optometry has been recognized in most of the states as a profession for the better part of the past century. The transformation of optometry from the business of selling spectacles in jewelry stores to working as opticians located in jewelry stores, to refracting opticians, to its current much expanded professional role has been amazing, especially when compared to the more gradual development of most other health care professions. Yet, this rapid change has provided ethical challenges, as some in optometry have had difficulty shedding certain trappings of years past, which impacts the public's perception of the profession.

**CASE 2**

*An optometrist who practices in a state where the law has been changed to permit the treatment of glaucoma decides not to go through the additional work necessary to qualify to treat this condition. This decision requires some patients to seek comprehensive eye care elsewhere. In addition to costing patients the convenience and savings of receiving the care needed within their optometrist's office, the optometrist's choice may suggest that optometrists in general are not qualified to provide such care. How might an optometrist limit his or her practice without negatively affecting patients, as well as the reputation of the profession?*

Examining a patient's eyes and vision and prescribing of appropriate eyewear are professional activities, whereas the selling of eyeglasses and contact lenses is considered a business enterprise by many, especially by those who purchase them. But some optometrists also consider dispensing eyeglasses and contact lenses as providing professional services. Ideally, the manner in which eyewear is marketed and dispensed within a practice would in most cases make this distinction clear wherever a particular practitioner draws the line between professional and commercial services.

When both examination and prescribing on the one hand and marketing and dispensing activities on the other hand occur within the same office, it is difficult for many members of the public to distinguish between the professional and business activities of the doctor. Moreover, optometrists have been able to significantly reduce charges for optometric professional services because they could shift a significant portion of their strictly professional charges onto the cost of eyewear. Historically, this cost shifting onto the charges for eyewear seriously misled the public, for whom the professional activity of the optometrist appeared to be

almost without cost. In recent years, there has been some shift away from this trend as most optometrists have started billing more appropriately for the value of their professional services.

The antitrust court decisions and government regulations of the 1970s also limited the degree to which individual states could regulate or limit health professionals' advertising and other business aspects of managing a practice. The result was an increase in prominent marketing activities. The public image of optometry has probably suffered as the result of some television and print advertisements that may distort the fact that most doctors of optometry work hard to keep business considerations from compromising the professional qualities of their relationships with patients.

What happens if business choices begin to interfere with the doctor's professional obligations? What happens when choices are made more to protect or enhance the business interests of the doctor than to meet the needs of the patient? How does a doctor, who must operate a sound business in order to provide optometric care to patients, strike the proper balance between professional and business interests? What happens when corporate optical entities become involved? Who is responsible for making these business decisions (especially if they impact the professional services rendered): the optometrist whose personal reputation and ethical standards are at risk or a corporate board of directors whose primary responsibility is to shareholders rather than to patients? In testimony before the Federal Trade Commission (FTC), Dean Alden Norman Hafner of the State University of New York acknowledged the right of these corporate entities to fit and dispense eyeglasses at retail but challenged their right to control professional care. "Their right to fit and dispense eyeglasses at retail is not in dispute. But I challenge the right of the corporate– commercial behemoth to perform professional care and to render to human service needs. That is neither their function nor their right. The business of selling eyeglasses in the marketplace is theirs. But professional concerns for standards for meeting human service needs are properly our concerns as doctors of optometry and those concerns cannot be discharged in the marketplace".

Consider the following efforts to bring new patients into a practice, as well as to develop additional revenue from the patients who are already there: Are patients' interests well served when elective procedures are promoted with apparent financial inducements? What are the ethics of advertisements promising a $1 charge for a "complete eye exam" with the purchase of a frame and premium lenses at the time of the examination? How about a promotion that asks the patient to schedule a complimentary surgical evaluation and to ask the doctor during that visit how they can win $1,000 off their laser vision correction, or the promise to earn 25,000 frequent flyer miles for laser vision treatment of both eyes?

Another ethical issue, if not a legal issue as well, is the legitimacy of selling manufacturers' free product samples, pharmaceuticals, contact lenses, supplies, etc. Or should a practitioner ethically accept any inducement of financial value from a manufacturer for the sale of pharmaceuticals or ophthalmic materials prescribed for the patient by that practitioner? Is this different from the profit made from selling eyeglasses, for example, and if so, why? Does it matter if the product is safe and "adequate" for the patient but maybe not the best choice for the patient? Are such actions rendered more ethical if the optometrist explicitly informs the patient about the inducements, or may the doctor assume that patients know about such financial inducements because of what they have heard in news reports?

**CASE 3**

*Dr. Jones has just completed a diagnostic fitting of two brands of contact lenses for Mary. Both of the final trials provide excellent visual acuity and comfort. Both are safe and adequate lenses for the patient. However, Dr. Jones is able to purchase one brand for half the cost of the other because of a special inducement to him by the manufacturer to try this new lens. He has a standard fee for fitting contact lenses and the first 6-months supply of lenses. If he chooses to provide the lenses that cost him the least, should he reduce his total fee to Mary by the lower cost of lenses or is it okay to keep his standard fee, not tell Mary, and benefit personally from the increased profit margin?*

The practitioner can find ethical guides and standards from various professional and corporate associations, as well as federal guidance from the Prescription Drug Marketing Act (PDMA) and the Health Insurance Portability and Accountability Act (HIPAA), to name a few sources. The reader may wish to access these sources and others for more information to guide his or her actions in specific circumstances.

## ETHICS AND THE LAW

Many practitioners do not make a distinction between ethics and the law, although the law at best only sets the floor for behavior below which the practitioner should not fall. Ozar notes, "It is important to distinguish moral or ethical issues regarding professional practice from legal issues. That is, questions about what is morally or ethically required or permitted are logically distinct from questions about what is legally required or permitted. While the law may direct a person to do what is morally correct, the law is not a fundamental determinant of what is morally correct, which is why we look to morality to tell us what the law ought to be, rather than vice versa." Ozar also observes that, in setting practice strategies, questions about the impact of law must be considered. If the law is supportive of morality, then there is no problem. However, if it is determined that required action of the law is not ethical, then there is the need to change the law, or take some other action. Not all actions that are legal are necessarily ethical from a professional ethics point of view.

**CASE 4**

*In the early 1990s, dentists across the United States chose not to treat patients with acquired immunodeficiency syndrome (AIDS) for fear of becoming infected. Some optometrists did the same. Some states and courts have legislated or adjudicated this issue that directly confronts the issue of whether health care practices are considered public or private. If considered private, then in most cases, doctors have the legal right to refuse to offer care. If considered public (funded by state or federal funds), then they may not have that right. Regardless of the legality in a particular state or jurisdiction, what does the reader think would be the most ethical action and why?*

Ethical obligations often demand behavior that extends beyond the law and often before a law to regulate practice or protect patients even exists. Law is never complete and cannot possibly address all circumstances begging attention from moral norms. As noted by Stone, it is when the market inadequately controls the behavior of marketplace entities within socially desirable bounds, that society through its legislative process passes laws to protect the public. But there is a time-lag between when a breach of the public trust occurs and when a regulatory law is passed. During this period, the duty to act ethically and professionally still prevails in the absence of societal controls. Stone points out that the laws passed by society to protect society against abuses are often influenced by the very corporate and association interests being regulated, making the law to some degree an agreement of government with those being regulated. The influence of those regulated on the law may not always serve the best interests of the public. One would hope that this interaction would result in an agreement that is fair to all; however, Stone also points out that even when consent is achieved, that implementation of the newly passed law may be difficult.

The previously mentioned PDMA does have a provision that should be understood as the legal basis for avoiding one behavior that may be tempting to some optometrists. The Food and Drug Administration (FDA) Website states, "The most simple and straightforward of the acts prohibited by the PDMA is knowingly selling, purchasing, or trading, or offering to sell, purchase, or trade a prescription drug sample." See 21 U.S.C. §353(c)(1). This offense is punishable by up to 10 years imprisonment. An article by Annunziato and Coble on the appropriate use of pharmaceutical samples in the optometric practice based on surveys with practitioners and pharmaceutical company representatives offers some guidance for ethical and legal practice.

## FORMS OF HEALTH CARE ORGANIZATIONS

In describing health care organization types, among which an optometric practice could be situated, Weber differentiates between a commercial model and a service model of health care. This differentiation asserts that a health care organization that is based on a commercial model would be devoted to a high return on investment and would see any expenditure for patient care as an expense. Weber believes that this is an inappropriate model for health care. In the service model, he sees health care organizations, such as optometric practices, as fundamentally humanitarian delivering health care needs to the community. In the service model, financial accounting for patient care would be seen as services delivered rather than expenses. Weber would acknowledge that optometric practices, like any other business, must focus on the practical business implications of decisions and give attention to the bottom line to remain viable. He would argue, however, that the way one thinks about the nature of their optometric practice would set the ethical tone of the practice. Optometry is a business, but it is unlike organizations that are only businesses in that it has a social obligation to care for those in the community with eye and vision problems. Eye care is not a commodity to be sold like any other commodity but rather is a delivered social service for which the practitioner may generally expect reasonable reimbursement to remain of service to others. In affirming the importance of ethics and for-profit healthcare, Weber states, "there is a long tradition of for-profit [health care] businesses . . . willingly making decisions expected to result in lower profits in order to avoid harm to the community." So it is reasonable to expect a profit from an optometric practice, but accepting lower profits when necessary to be professionally and socially responsible to patients and community would be expected of the ethical optometric practice.

But what if the profit motive becomes the major goal of an optometric practice? Goodpaster would suggest that a practice so fixated on profits will likely rationalize questionable business behaviors to justify efforts to achieve its goal. Any thoughtful questioning of practice behaviors by staff or others would be discouraged and likely viewed as a lack of loyalty. Over time, the optometrist and staff would become detached from and suppress any critical questioning of practice actions. Fixation, rationalization, and detachment would be symptoms of an unethical illness. In the absence of ethical evaluation, fiscal goals or objectives become idols and critical questioning or other obstacles become threats to the point that second thoughts are not allowed. Ethical awareness, if allowed to flourish, offers protection to selfish excesses that may arise in the management of an optometric practice. Conscience must be allowed to prevail.

When driven by selfish motives, it is easy for both the optometrist and staff to use selective perceptions, which narrows judgment in such a way that outcomes that meet the business goals of the practice may prevent consideration of outcomes that would be more appropriate for a health care practice. Ambition to be seen as one of the top producers among colleagues can distort reality in that the top earning optometric practice may not be the top in quality or caring. Yet, we must be careful not to lump all financially successful practices into a category of self-indulgence that neglects the primary eye and vision care mission of optometry. A well-organized and efficient practice that is financially successful may well be among the best in the delivery of quality cost-effective care. The potential for the latter is definitely a possibility.

Like most things in life, there are opposing viewpoints when economists speak of the for-profit market place. Solomon and Hanson note that "Business life is obviously concerned with the pursuit of money, both in profits and in growth, whether in the size of the company or in a person's own status and position … Before [the 1500s], seeing a profit was roundly condemned by both religion and social mores as avarice; jobs tended to be inherited from the family or better luck elsewhere; the idea of rising above a person's station in life was considered dangerous and disruptive to the social fabric as a whole; and prices were generally fixed, both in the Bible and by the secular authorities, as nothing more than a fair price, which meant precisely wages for labor, and nothing more—no interest, no profits, no bargains, no adjustments for supply and demand, and no attempts to create a consumer market for goods where new ideas could eclipse these older notions."

Goodpaster notes that Adam Smith points out in *Wealth of Nations* that "It is not from the benevolence of the butcher, the brewer, or the baker, that we expect our dinner, but from their regard to their own interest." The new assumption of individualism became gospel with the publication of Smith's book in 1776, which was also the same year the American Declaration of Independence was signed. The theory Smith defended, generally referred to as the *free-enterprise system*, is that individual members of society, left alone to pursue their own economic interests, will ultimately benefit not only themselves but also society as a whole. As Smith imaginatively put it, an invisible hand would guide apparently chaotic individualism to the collective good. More generally, the theory suggests that what now could be called the market could and should be allowed to operate independently of social and governmental interference and control. In doing so, the whole society would greatly improve and become wealthier and better off not only materially but also spiritually as well.

Adam Smith's suggestion that an invisible hand would guide chaotic individualism to the collective good of society over time has been disputed. Instead, time has shown that individual business excesses [greed] often harm too many individuals to allow time alone to correct for the damage caused. Typically, the correction occurs with government regulatory intervention being invited by the public. It is also often overlooked that when Adam Smith talked about individuals' pursuit of their own interests, he assumed that these interests included other people besides themselves (i.e., that individuals' interests were in part formed by their sympathy for others' well-being), as Smith had argued at length in his earlier book, *A Theory of Moral Sentiments.* It is hoped that members of the profession of optometry will not allow their personal interests and greed to drive government to further regulate the management of optometric practices. Much of business ethics centers on the principle of justice, or the fair distribution and utilization of limited resources. The organizational form of an optometric practice should enable it to carry out this duty, and Weber's service model seems best suited to this end.

## POINTS TO CONSIDER DURING ETHICAL ANALYSIS

Different value or ethical systems move interchangeably and constantly in society, as well as in the management of an optometric practice. One system may seem more important to the resolution of a given business conflict at a given moment, but all should be considered.

Hosmer lists 6 ethical systems that should be considered in ethical analysis. The first he mentions is the principle of *eternal law,* revealed in writings or apparent in nature, which is typically interpreted by religious leaders or humanist philosophers. The principle of *personal virtue* refers to the moral standards that define the character of a person as honest, trustworthy, kind, etc. The principle of *utilitarian benefits* encourages individuals to act in ways that produce the greatest possible benefits for others or society, rather than acting for the sole benefit of the self. The principle of *universal duties* places emphasis on actions that justify either the ends or the means (i.e., which is of greater moral value, the outcome or the means used to achieve the outcome?). The principle of *distributive justice recognizes* fairness in the use of limited resources. The principle of *contributive liberty* requires that no action be taken that would interfere with the rights of others.

Hosmer points out that each of the ethical systems has adherents and opponents. While none of these systems is complete or wholly adequate on its own to address all ethical concerns in optometric practice, this fact does not justify the optometrist in pursuing his or her own interests at the expense of other moral considerations, especially his or her professional obligations. Hosmer states that "difficulty comes in identifying our obligations and then in evaluating our alternatives, with no single set of moral standards to guide us."

What should we do? It has been suggested that "instead of using just one ethical system, which we must admit is imperfect, we have to use all 6 systems and think through the consequences of our actions on multiple dimensions." Is the decision honest and one which will enhance others' trust of the profession and oneself? Is the proposed action kind and compassionate? Will the action result in greater benefits than damages for society as a whole, not just for our practice as a part of that society? Is the decision self-serving, or does it consider others? Will our decision increase or decrease the willingness of others to participate and see themselves as having a fair voice in matters that affect them? And finally, does our decision increase or decrease the freedom of others to act? Stated in another way, as an optometrist, ask yourself the following:

1. Am I, or the person to whom I have delegated responsibility, qualified to render the services being provided?
2. Are all the services I am providing necessary?
3. Is the care being provided the most appropriate and prudent?
4. Have all of the services for which I am billing been provided?
5. Are my patients being fairly charged?

Ethical decision making that utilizes all ethical systems is not easy, but it is worthwhile to attend to each perspective if

one goal in ethical judgment is to be reasonably successful. When it is possible to combine this decision making with legal requirements and desired ethical outcomes, everyone wins.

## ETHICAL ANALYSIS: THE PROCESS

Whenever a situation arises where discomfort is confronted in deciding what action ought to be taken, the thoughtful person will attempt to resolve the conflict through a critical thinking process. The process should be logical and not unlike that which would be necessary to resolve any problem in life, moral or otherwise.

Individual conflicts may be easier to resolve than those conflicts that involve multiple parties (i.e., other individuals or groups). It is not enough to make up your own mind; you have to be able to justify your chosen action to others by convincing them of its merits, even if no one is actually asking. Frequently, power may play an unfair or unjust role when those in a management position direct an action that may be questionable to others who have a different set of values. We cannot ignore conflicts in favor of the more powerful; the earlier discussion of selective perceptions that can stymie critical thought and more appropriate action by an optometric practice should be remembered.

The following is the ethical decision-making process described in *An Optometrist's Guide to Clinical Ethics*, modified to apply more aptly to practice management problems. However, the critical thinking process is the same and can be applied when making value-based decisions in the management of an optometric practice. Developing this critical thinking process so that it becomes part of the optometrist's skill set is more important here than trying to give the "best" ethical response to specific value-based practice management problems.

1. The stepwise process of ethical decision making in this framework begins first with recognizing that an ethical problem exists. For the more subtle ethical issues, this may be more difficult than many realize. To the ethically sensitized optometrist, the awareness of one's negative emotional response to a given business situation can be the clue that values are in conflict.
2. All of the relevant facts surrounding the issue need to be established, much as the optometrist would do in gathering clinical data to rule out or diagnose eye and vision problems. This fact gathering should be as impartial and nonjudgmental as possible to prevent the exclusion of points that may subsequently prove to be important to a management decision. Identifying all of the parties involved and their concerns is important.
3. The professional ethical values and principles that apply to the given situation should be identified, as well as noting where they are in conflict. Guidance may be found in the Code of Ethics, The Optometric Oath, one or more of the AOA House of Delegates' resolutions, and related literature. Do any of the conflicting values hold greater importance than the others (i.e., is there a hierarchy among the values in question)? In addition, are there any laws or other authoritative positions that may apply?
4. All possible courses of action and their likely outcomes if implemented must be identified. Some alternatives may be more practical than others, and the seemingly more ideal may be difficult or impossible to initiate. Then, in the critical analysis of these alternatives, the six principles of ethics listed previously by Hosmer should be considered, along with relevant professional standards. The goal is to see how well each possible course of action fits the demands of each principle and standard.
5. The next step in the decision-making process is to judge and then choose to undertake the course of action that is best supported by the analysis done in the fourth step. This may not be easy and there may be a tendency to avoid a decision altogether, leaving the outcome to outside forces. This latter behavior can be disastrous and is definitely inferior to giving critical thought and taking a reasoned action. It is ethically preferable and better risk management for the optometrist to act in a way that is believed in and is supported by a clear process of reasoning.
6. Once a judgment is made and placed into action, the stage is set for the final step, which is the monitoring of the action to see to what degree the outcome fits the outcome that was predicted. If the outcome is undesirable, then modifications will need to be made after further critical thought to bring conflicting values into an ethically appropriate resolution. It is frequently beneficial to consult with a colleague who may have had similar management conflicts.

Developing the skill of rationally analyzing management actions in relation to ethical values will serve the business aspects of the practice well. With thought and practice, the optometrist will develop an almost instinctive understanding of how to proceed when an ethical issue arises during the business management of the practice.

The following are sample case studies with which the optometrist can practice the ethical principles and decisionmaking process as discussed.

**CASE 5**

*An optometrist refuses to see patients who are on Medicaid (financial assistance for the needy) because his state Medicaid office pays only $40 for an examination for which he normally receives $75. Other optometrists in the community do accept Medicaid patients. Should this optometrist accept Medicaid patients as a matter of ethics, or if not, on what ground might it be acceptable to refuse them?*

**CASE 6**

*A patient with a foreign body embedded in his eye seeks care from an optometrist in a state where the law says that a person who volunteers to render emergency care can be held liable if he or she is negligent. What ethical issues should the optometrist consider before agreeing or refusing to see the patient?*

**CASE 7**

*An optometrist learns that an ophthalmologist to whom she routinely refers patients has been making disparaging remarks to these patients about the optometrist's competence. The nearest other ophthalmologist is 30 miles away. What ethical options does the optometrist have when she needs to refer patients for surgical care?*

**CASE 8**

*A 60-year-old patient has a cataract, but the effect on the patient's acuity is minimal (reduced to 20/25) and the patient has no complaints. What should the optometrist tell the patient about the cataract, based on what ethical grounds?*

**CASE 9**

*An elderly man is examined by an optometrist and found to have greatly reduced visual acuity, below the 20/70 level necessary to operate a motor vehicle in that state. What ethical obligations does the optometrist have to report this finding voluntarily to the Department of Public Safety or Department of Motor Vehicles, which awards driver's licenses? What ethical obligations does the optometrist have to the patient and his family?*

**CASE 10**

*A patient is referred to you for a contact lens fit by an optometrist who does not fit contact lenses. After you fit the patient with contact lenses, the patient asks you to provide a pair of glasses also. As a matter of ethics, would you provide them or refer the patient back to the referring optometrist?*

**CASE 11**

*A patient of yours is in need of cataract surgery and insists on having an ophthalmologist who she met at a social function perform the surgery. You know that this surgeon is one of the least proficient in your community. Ethically, what should you tell your patient?*

**CASE 11**

*Your partner in practice is getting ready to retire, and you discover that your partnership agreement may contain a flaw with regard to how your purchase of your partner's share of the practice is to be calculated. Interpreting the contract as written may afford you a huge financial benefit, but you know that was not the way either of you intended the contract to be written. How do you address this unexpected finding with your partner? Do you try to argue what you feel to be your legal right under the written contract or do you pay the amount that you know the two of you understood would be the amount when you entered into the partnership?*

## CONCLUSION

Most issues surrounding the ethical conduct of business in an optometric practice will not, as a rule, cause great difficulty in determining the right thing to do. Expected behavior may be dictated by previously set practice policy, legal decree, or by guiding ethical documents. However, there will be times when values and interests come into conflict and the optometric practice must apply critical thinking in the form of ethical reflection to arrive at the most appropriate course of action.

"It's not always easy to know what to do." — Humphrey Bogart as Sam Spade in The Maltese Falcon

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## BIBLIOGRAPHY

Annunziato T, Coble JD: Appropriate use of pharmaceutical samples in the optometric practice, *J Am Optom Assoc* 405–412, 2006.

Bailey RN: The history of ethics in the American Optometric Association 1898–1994, *J Am Optom Assoc* 65(6): 427–444, 1994.

Bailey RN, Heitman E, editors: *An optometrist's guide to clinical ethics*, St. Louis, 2000, American Optometric Association.

Dorrity TF, Bailey RN: Standards of care and collegial relations. In Bailey RN, Heitman E, editors: *An optometrist's guide to clinical ethics*, St. Louis, 2000, American Optometric Association.

Heitman E, Bailey RN: *Ethical issues in contact lens practice*, St. Louis, 2008, American Optometric Association.

Heitman E, Bailey RN: Ethical decision making in clinical practice. In Bailey RN, Heitman E, editors: *An optometrist's guide to clinical ethics*, St. Louis, 2000, American Optometric Association.

Goodpaster KE: *Conscience and corporate culture*, Malden, MA, 2007, Blackwell Publishing.

Hosmer LT: *The ethics of management*, ed 4, Boston, 2003, McGraw-Hill.

Ozar DT: Profession and professional ethics. In Post SG, editor: *Encyclopedia of bioethics*, ed 3, New York, 2004, Macmillan Reference USA/Gale.

Ozar DT: Building awareness of ethical standards and conduct. In Curry L, Wergin JF, and Associates editors: *Educating professionals*, San Francisco, 1993, Jossey-Bass Publishers.

Smith A: *The theory of moral sentiments*, Edinburgh, 1759.

Solomon RC, Hanson KR: *Above the bottom line: an introduction to business ethics*, New York, 1983, Harcourt Brace Jovanovich, Inc.

Stone CD: Why the law can't do it. In Donaldson T, Dunfee TW, editors: *Ethics in business and economics*, vol I, Brookfield, VT, 1997, Ashgate Publishing Company.

Thomas J: A guide to ethics in 2002 and beyond, *Optom Manage* (Sept): 52–57, 2002.

United States Food and Drug Administration: *The prescription drug marketing act of 1987*. Available at: http://www.fda.gov/RegulatoryInformation/Legislation/FederalFoodDrugandCosmeticActFDCAct/SignificantAmendmentstotheFDCAct/PrescriptionDrugMarketingActof1987/default.htm.

Weber LJ: *Business ethics in healthcare*, Bloomington, IN, 2001, Indiana University Press.