APPENDIX 2

Revised Ethical Standards for Optometrists and Dispensing Opticians

Professor Ron Paterson, 10 February 2020

Background

As regulator, the Optometrists and Dispensing Opticians Board (ODOB) has the function, under the Health Practitioners Competence Assurance Act 2003 (HPCAA), of setting 'standards of clinical competence, cultural competence (including competencies that will enable effective and respectful interaction with Māori), and ethical conduct to be observed by health practitioners of the profession' (s 118(i)).

ODOB has fulfilled the function literally, by issuing documents entitled 'Standards of Clinical Competence for Optometrists' (2018) and 'Standards of Clinical Competence for Dispensing Opticians' (2016), which 'are to be observed' by members of the professions; 'Standards of Cultural Competence' (2018), 'to provide a benchmark by which practitioners [of both professions] can be guided'; and 'Ethical Standards for Optometrists' (2012), which 'offer guidance only', and 'Standards of Ethical Conduct for Dispensing Opticians' (2014), which are described simply as standards.

ODOB has also recently issued a 'Guideline on the Maintenance of Professional Boundaries for Optometrists & Dispensing Opticians' (2019), which covers a topic that is an important dimension of ethical practice.

Relevance of standards set by Board

Traditionally, codes of ethics have been issued by professional associations, such as the New Zealand Association of Optometrists, whose Code of Ethics (2011) forms the basis of the 'Ethical Standards for Optometrists' (2012) issued by ODOB. However, there is an important difference between a profession's own statement of its ethical values and principles. Such documents are often aspirational in tone – for example, the NZMA Code of Ethics (2014), principle 8: 'Honour the profession, its values and its principles in the ways that best serve the interests of patients.' In contrast, ethical standards set by regulators articulate a minimum standard that practitioners are required to comply with.

The position is well summarised in a leading text:

'In short, the law provides a minimum standard, while ethics acknowledges a minimum standard (which is not always the same as law) but strives for the maximal standard.'

'The community, through the judiciary, can challenge the professions to change their ethics standards so that the professions stay in touch with community expectations.'

'Code of ethics need to be more than window dressing, and there is a strong potential for criticism if the values enshrined in them are thought to be either rarely enforced or applied by practitioners. ... [P]rofessionals also need some mechanism for giving effect to those ethics, beyond that of the virtue of the individual health care worker.'
(C Berglund, *Ethics for health care.* OUP, 4th ed., 2012, pp 206, 207, 36).

Ethical standards promulgated by a responsible authority are given statutory recognition under the HPCAA. They become legally enforceable under right 4(2) of the Code of Health and Disability Services Consumers' Rights (the HDC Code), which states that 'Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards'. Thus, breach of an ethical standard could form the basis of a complaint to HDC and, after investigation, a finding of breach of the Code. A serious lapse in ethical behaviour could also lead to a disciplinary finding of 'professional misconduct', which is defined to include conduct by a practitioner that is 'likely to bring discredit to the profession' (HPCAA, s 100(1)(b)).

Ethical standards issued by a board may also be relied on in other contexts, such as an employment dispute. In *Evans-Walsh v Southern District Health Board* (2018) 15 NZELR 840, the Employment Court upheld a DHB's actions in reporting bullying concerns about a nurse, who had resigned following an employment dispute, to the Nursing Council. The Court found that the 'Nursing Council's Domains and competencies go beyond patient care and apply to ethical matters such as the way in which nurses deal with each other. The Code of Conduct has a similar reach.' [44]

What have other NZ boards done?
Other health regulators in New Zealand have carried out their s 118(i) HPCAA functions in range of different ways. This suggests that there is no single 'right' way to issue standards. For example, the *Medical Council* has issued nine standards relating to 'Conduct and professionalism' which cover central ethical issues in practice. The Medical Council standards 'set out the behaviour the Council expects of doctors' but are not described as ethical standards. They include standards on: 'What to do when you have concerns about a colleague' (2010), 'Professional boundaries in the doctor-patient relationship' (2018), 'Sexual boundaries in the doctor-patient relationship', Statement on providing care to yourself and those close to you' (2016) and 'Doctors and health related commercial organisations' (2012).

The *Occupational Therapy Board* of New Zealand has issued a 'Code of Ethics' (2015), in pursuance of s 118(i), to describe 'the standards of ethical conduct expected of all occupational therapists registered to practise in New Zealand', with a two-fold purpose of informing and protecting current and potential clients, and protecting the integrity of the occupational therapy (OT) profession. The OT Code of Ethics is a set of three principles relating to (1) relationship with those receiving OT services; (2) relationship with society and potential clients; and (3) relationship with colleagues and the profession. Each principle is described as a series of duties that an OT 'shall' comply with.

There is an attractive simplicity to the OT Code, which in five pages sets out clear statements of expected ethical conduct, with cross references to relevant guidelines and legislation. For example, under principle 2, relationship with society and potential clients, it specifies:

2.1 Occupational therapists shall accurately represent their skills and competences.
Occupational therapists shall:
2.1.1 accurately represent their skills and areas of competence to potential clients, including employers, whether those services are to be provided directly or indirectly. An area of competence will be supported by demonstrable training, knowledge, experience, and skill.

The *Dental Council* of New Zealand has issued a 'Standards Framework for Oral Health Practitioners' (2015), which sets out five ethical principles registered oral health practitioners 'must adhere to at all times': 1) put patients' interests first; 2) ensure safe practice; 3) communicate effectively; 4) provide good care; and 5) maintain public trust and confidence. The principles are backed by 28 mandatory professional standards (eg, for ethical principle 5, maintain public trust and confidence, professional standard 23 states: 'You must ensure your professional and personal conduct justifies trust in you and your profession'), with guidance provided for each standard.

The *Nursing Council* of New Zealand has issued a 'Code of conduct for nurses' (2012), in pursuance of s 118(i), 'describ[ing] the behaviour or conduct that nurses are expected to uphold', which 'provides guidance on appropriate behaviour for all nurses and can be used by health consumers, nurses, employers, the Nursing Council and other bodies to evaluate the behaviour of nurses'. The 48-page Code was developed after a lengthy consultation process with the profession, the health sector, Māori and consumer organisations. This included consultation on a draft Code (resulting in 74 submissions) and three focus groups with nurses and health consumers. There was strong support for a move to making standards of professional behaviour more explicit.

The Nursing Code of Conduct begins with a statement of eight core principles of ethical nursing practice, which are linked to four key ethical 'values underpinning professional conduct': respect, trust, partnership and integrity. The eight principles are underpinned by detailed standards – for example, principle 1, 'respect the dignity and individuality of consumers', lists ten standards, such as 1.7, 'Do not prejudice the care you give because you believe a health consumer's behaviour contributed to their condition.'

The most significant change in the new Nursing Code is the addition of a new principle, 'respect the cultural needs and values of health consumers', with six of ten standards under that principle devoted to working with Māori:

2.5 Work in partnership with Māori health consumers and their whānau/family to achieve positive health outcomes and improve health status.
2.6 Understand Māori health inequalities and pay particular attention to the health needs of the community you nurse in.
2.7 Ensure nursing care is culturally appropriate and acceptable to Māori health consumers and their whānau, and is underpinned by the recognition that Maori are a diverse population.
2.8 Acknowledge and respond to the identity, beliefs, values and practices held by Māori, and incorporate these into nursing care.
2.9 Integrate Māori models of health into everyday practice and when developing care plans.
2.10 Promote access to services which meet the needs of Māori health consumers.

The *Physiotherapy Board* has issued a Physiotherapy Standards framework (2018, 35pp) 'to provide a benchmark of minimum standards expected of physiotherapists in New Zealand'. As well as Physiotherapy Standards, which 'describe in detail the expected minimum clinical and cultural standards for ... physiotherapy', the framework includes a Physiotherapy Code of Ethics and Professional Conduct, which aims 'to cover areas of ethical concern most commonly experienced by physiotherapists', based on a set of ten principles. 'The Code is to be used by the Physiotherapy

Board as a standard by which a physiotherapist's conduct is measured'. The Code is expressed as rules that a physiotherapist *must* comply with. For example, Principle 1, 'Physiotherapists respect the patient and their whānau and families', states:

'The relationship between physiotherapist and their patient is one of trust, and as such physiotherapists must

1.1 respect the dignity, privacy, bodily integrity, and mental wellbeing of patients
1.2 conduct themselves in a respectful manner towards the patient as well as their whānau, family and carers.
1.3 practise with due care and respect for a patient's culture, needs, values, worldviews and beliefs, including Te Ao Māori.
1.4 not impose their own values and beliefs on patients or their whānau and family.'

Extensive cross-references are provided to relevant provisions of the Physiotherapy Standards, the HDC Code and other legislation.

Comparable regulators internationally

The *Optometry Board of Australia* (which regulates optometrists only) has issued a 'Code of conduct for optometrists' (2014, 15pp), pursuant to the discretionary function give to all National Boards under the Health Practitioner Regulation National Law, s 39, to 'develop and approve codes and guidelines', after 'widespread consultation' (s 40), which are then admissible 'as evidence of what constitutes appropriate professional conduct or practice' for the health profession (s 41).

The Code of conduct for optometrists 'seeks to assist and support optometrists to deliver effective health services within an ethical framework'. It contains 10 standards for optometrists' behaviour, in relation to:

1. providing good care
2. working with patients
3. working with other practitioners
4. working within the health care system
5. minimising risk
6. maintaining professional performance
7. professional behaviour
8. ensuring health
9. teaching, supervising and assessing
10. undertaking research.

Under each standard, specific examples of the relevant conduct are provided, for example:

1.2 Good care

Maintaining a high level of professional competence and conduct is essential for good care. Good practice involves:

(a) recognising and working within the limits of an optometrist's competence and scope of practice ...

Many of the standards cover good practice in domains that, in New Zealand, are covered by the standards of Clinical Competence for Optometrists or Dispensing Opticians. One standard, 7, focuses on ethical behaviour, with sections relating to professional boundaries and conflicts of interest.

The *General Optical Council*, which regulates optometrists and dispensing opticians in the United Kingdom, has issued 'Standards of Practice for Optometrists and Dispensing Opticians' (2016, 15 pp), pursuant to its statutory function 'to promote and maintain public confidence in the professions' (Opticians Act 1989, s 1(2B)(c)). The Standards of Practice 'define the standards or behaviour and practice [expected by the regulator] of all registered optometrists and dispensing opticians. There are 19 standards, prefaced by the statement 'The care, well-being and safety of patients must always be your first concern.' Each standard lists relevant expected behaviours. For example, standard 7, 'Conduct appropriate assessments, treatment and referrals':

7.5 Only provide or recommend examinations, drugs or optical devices if these are clinically justified, and in the best interests of the patient.

As with the Code of conduct for optometrists in Australia, the General Optical Council Standards of Practice are a mix of standards related to good clinical practice and others more obviously related to ethical conduct (e.g., standard 13, show respect and fairness to others and do not discriminate; standard 15, maintain appropriate boundaries with others; standard 16, be honest and trustworthy).

Although it is not a regulator, the World Council of Optometry has published an Optometrist Code of Conduct that nicely summaries the ethical responsibilities of an optometrist:

1. Keep your patient's eye, vision and general health your first priority
2. Respect the rights and dignity of patients regarding their health care decisions
3. Advise your patients whenever consultation with, or referral to, another optometrist of other healthcare professional is appropriate
4. Ensure confidentiality and privacy of patients' health and other personal information
5. Strive to ensure that all people have access to eye and vision care
6. Advance your professional knowledge and skills
7. Maintain your practice in accordance with professional health care standards
8. Promote ethical and cordial relationships with all members of the health care community
9. Uphold the dignity, honour and integrity of the optometric profession.

Critique of current Standards of Ethical Conduct for Optometrists and Dispensing Opticians?

The current Standards were issued by ODOB for the two professions in 2012 and 2014. As noted earlier, the Ethical Standards for Optometrists mirror the NZAO Code of Ethics. Some of the statements read as quaint in 2020 ('treating all ... kindred professionals with fairness, honesty, respect and understanding', standard 2). Others are so general as to be meaningless ('understand the concept of duty of care', standard 3). Some seem more concerned with professional status than the wellbeing of patients ('enhancing the status of the profession', standard 8.) Some set a low bar for ethical behaviour ('disclose any *significant* proprietary interest ... in the care options recommended', standard 4).

The Standards of Ethical Conduct for Dispensing Opticians exhibit a different range of problems. They are a curious mix of policy (including the arguable claim that dispensing opticians 'who believe, in good faith, that a colleague has breached ethical standards are obliged to bring that matter to the attention of the Board'), legal rules (section 1.1 lists codes and statutes that DOs are required to comply with), standards relating to ethical matters (section 2.1, responsibility to the patient, covering patient welfare, non-discrimination, informed consent, and referral when necessary) and standards of care (which more naturally fall within the separate Standards of Clinical Competence).

Neither of the Ethical Standards covers the issue of the maintenance of professional boundaries between practitioners and patients – though ODOB has filled this gap by issuing a specific Guideline on the Maintenance of Professional Boundaries for Optometrists & Dispensing Opticians (2019). This guideline followed an HDC case in which a dispensing optician was criticised for making sexual advances to a patient, and the Deputy Commissioner recommended that ODOB 'consider implementing a standard that requires dispensing opticians to maintain professional boundaries with consumers at all times' (case 16HDC00916, 20 December 2017).

The new boundaries guideline is lax in some areas, notably treating friends and family, which is described as 'not unusual' and seemingly acceptable so long as it meets clinical and ethical standards (an inherent contradiction) and clinical objectivity is maintained. Self-care / prescribing is also not clearly frowned upon; instead, it is described as an area where, 'when in doubt, seek advice from an independent practitioner'. The ODOB Guideline on this issue may be contrasted with the Medical Council's 'Statement on providing care to yourself and those close to you' (2016).

The current Ethical Standards revision is an opportunity for ODOB to clearly state key ethical principles and values, and underline the minimum standard of ethical conduct expected of practitioners. Despite the differing training and practice of optometrists and dispensing opticians, there is no reason why the fundamental ethical standards should differ between the two professions. Interestingly, there has been discussion in Australia about moving to a common Code of Conduct (including ethical conduct) across the 15 health professions regulated by separate boards under the National Law.

Ethical issues in optometry

In my interviews with key practitioner informants during this review, similar ethical issues were raised by members of both professions. A common theme was concern about the risk of loss of professionalism with increasing moves to commercialisation and corporate practice. This is a longstanding issue – a history of the American Optometric Association noted that 'the problems of commercialism, of being labeled a business, of ethics, and of proper fee structure in large measure were inherited by optometry because of its very nature' (J Gregg, *American Optometric Association: A history*, 1972: 149-150).

Other ethics issues raised by interviewees related to duty of care (e.g., when to refer a patient; competence and the ageing practitioner) and respect for patients (especially the elderly). In discussion at the ODOB meeting in November 2019, informed consent and equity of access for Māori patients were noted as ethical concerns that should be highlighted in the revised ethical standards.

Emerging ethics issues include increased transparency of customer feedback via online reviews, and how to handle and respond to negative and positive feedback (see C Sykes, 'Facing the feedback, *NZ Optics*, 1 February 2018: http://nzoptics.co.nz/articles/archive/facing-the-feedback/). The maldistribution of the workforce, with eye care practitioners concentrated in Auckland and urban centres, has important implications for equitable access to eye care (see N Chapman, N Anstice, R Jacobs. Geographic distribution of eye care practitioners in Aotearoa / New Zealand: implications for future eye health workforce, *Clinical and Experimental Optometry*, online 30 November 2019).

The few reports of investigations into optometrists on the HDC website indicate that the quality of assessment and diagnosis is the main issue leading to breach findings (6 of 7 cases), with failure to provide sufficient information to a patient, and failure to refer to an ophthalmologist, also leading to breach findings. Thus duty of care and informed consent appear to be the underlying ethics issues canvassed in HDC reports on optometry cases: (https://www.hdc.org.nz/search-site?keywords=optometry)

One decision of the Health Practitioners Disciplinary Tribunal found an optometrist guilty of professional misconduct, cancelled her registration and censured her for failure to make appropriate arrangements to ensure continuity of care when her optometry business went into liquidation:
(*Re Buckingham*, HPDT Decision No 510/Opt12/217P, 14 February 2013,
https://www.hpdt.org.nz/portals/0/510POpt12217P.pdf

Recent amendments enacted by the Health Practitioners Competence Assurance Amendment Bill 2019 indicate areas of contemporary emphasis: enabling effective and respectful interaction with Māori (s 118(i)); promoting interdisciplinary collaboration and co-operation in the delivery of health services (s 118(j)); and transparency about regulatory performance, by regular, independent reviews of how effectively and efficiently a responsible authority is performing its functions, and publication of recommendations and actions taken (s 122A).

The revised standards also provide an opportunity to highlight a commitment to professionalism as one aspect of being an ethical practitioner. An analysis of professionalism in clinical training in optometry is the subject of project report from the College of Optometry (UK): *Professionalism in optometry: final project report* (2014). The project involved surveys of practitioners, interviews with stakeholders from universities, employers, regulators and representative organisations; and workshop with students and patients. There was broad agreement that professionalism in optometry is based on seven key qualities:

- communication
- ethics
- honesty
- being patient-centred
- integrity
- knowledge
- trustworthiness.

Professionalism in optometry was described as follows:

‘An optometrist who is honest and knowledgeable, acting ethically in the best interests of patients through:

- applying own knowledge and improving competence and critical judgement
- communicating effectively with patients, colleagues, other health professionals and the wider community
- actively following professional guidance.’

Considerations for revised Ethical Standards

As noted above, the current revision of the ethical standards is being undertaken by ODOB to set ‘standards of ... ethical conduct to be observed by health practitioners of the profession’ (HPCAA, s 118(i)). It should be seen in the context of the overall public protective purpose of the HPCAA, ‘to protect the health and safety of members of the public’ (s 3(1)), with its focus on competence assurance, and the subsidiary purpose of ‘a consistent accountability regime for all professions’ (s 3(2)(a)).

Otago bioethics lecturer Lynley Anderson writes that the key requirements of a coherent code of ethics (and presumably also of ethical standards) are that the resulting document is comprehensible and accessible by both patients and clinicians (i.e., the public and the profession); unambiguous (‘plainly expressed, clear in its requirements’) and compatible with existing codes and laws. ‘Excessive detail renders the code too long and unwieldy and threatens its usefulness.’ (L Anderson, Writing a new code of ethics for sports physicians: principles and challenges, *British Journal of Sports Medicine* (2009) 43: 10791082.) Given the wish to develop common ethical standards for optometrists and dispensing opticians, consistency is a further aim of the revised standards.

Underlying ethical principles

Four ethical principles, introduced by American philosophers Tom Beauchamp and James Childress in their classic work, *Principles of Biomedical Ethics* (1985), have been widely accepted as a useful framework for thinking about ethics in health care. The principles are:

- autonomy – respecting individual choices and decisions
- beneficence – doing good
- non-maleficence – avoiding harm
- justice – striving for fairness and equity.

The draft revised Ethical Standards may be assessed against the four principles, with the suggested standards reflecting autonomy (standard 1, Respect patients), beneficence and non-maleficence (standards 2 and 3, Care for patients and Work collaboratively with others) and justice (standard 4, Contribute to improving the health of the community).