Case: In 2017, an 87-year-old East Indian male walked into a privately-owned clinic where I was an employee, complaining of pain in his right eye. He did not speak any English, and I was asked to assist with translation. Results of the exam showed that the patient had suffered an accidental corneal abrasion. The exam was going smoothly, and the doctor and I were in the middle of explaining to the patient his prescribed medication routine, when the co-owner of the clinic aggressively knocked on our door and exclaimed that we were taking too long with this patient. He kept pressing that the other waiting patients were getting impatient, and it was time to wrap up the exam. The patient felt he was being a nuisance and apologized for taking up the doctor’s time. He sat quietly and did not ask any more questions. The doctor then proceeded to rush the end of the exam.

This case demonstrates a detrimental consequence of the dual perspective that exists when providing eyecare. Healthcare can be thought about in two different ways\(^1\). On one hand, we can think about providing health care as a service- like getting a haircut. On the other hand, we can consider healthcare a basic social need, and a direct tie to an individual’s wellbeing. Eyecare has always been viewed as a gateway to health\(^2\), and yet it is allocated as a market commodity instead of a social service. It is dispersed according to the ability to pay, instead of according to need\(^1\). Unfortunately, there is a huge mismatch between the two- meaning that those with the greatest need are the ones least able to pay. This one case itself has many ethical implications that can be brought into question, and although I would like to delve into each and every one of them, I have chosen to focus on the implications of the overarching idea of treating eyecare as a market commodity instead of a social service, and the resulting violation of the optometric oath. We will discuss this in three ways.

Firstly, treating eyecare as a market commodity is one reason that allows optometrists to partner with non-O.D. s, such as business owners, HMO corporations, military services etc. This often leads to a conflict of interest, as an optometrist has pledged an oath to prioritize the health of their patient, whereas the non-O.D has not. Often, the non-OD’s sole interest is in whether or not the clinic is turning over a profit, and what could be done to increase the profit margin. In the case mentioned above, the
patient in the doctor’s chair had come in for a significant eye concern, and his visit was to be compensated for by the government. The non-O.D. owner took his language barrier and worn-out clothes, among other things, as reasons to stereotype him as “poor.” The patient in the waiting room, however, had no health concerns. He was a wealthy middle-aged individual, who had come in for his yearly eye-exam with the intent of buying several pairs of glasses. For an optometrist, both these patients are equally important and should be treated with the same dignity, respect and time allotment as needed. Sadly, we can see that because of the conflict of interest between the two owners, the treatment of the two patients was not the same, and can be labelled an ethical violation.

The ethical violation that occurred can be explained using Immanuel Kant’s non-consequentialist theory of deontological ethics\(^1\). According to Kant, the central moral concept is that of duty, and how the goodness or badness of an act depends on the act itself, not the consequences of it\(^1\). Furthermore, Kant emphasizes that you must commit to never treating a person as a means to another end\(^3\). In the above-mentioned case, we see that one clinic owner sought to use his patients as a means to a better income. Ethically, what should have mattered is good quality of care to both patients seeking eyecare, irrespective of the monetary consequences of their visit.

Secondly, not providing eyecare as a social need leads to the discrimination of individuals based on their socioeconomic status. This can be realised in a variety of ways. For example, optometrists in the United States of America have the privilege to deny patients services if they are on Medicare or Medicaid\(^4\). This is justified because of poor reimbursement, cumbersome claim forms, payment delays and administrative burdens. What is failed to be acknowledged is that these patients are typically of lower socioeconomic status, are often more medically complicated, are more likely to need eyecare compared to other demographics in the United States, and are even more likely to face barriers to health and other healthcare services\(^4\). In addition, Medicare patients are more likely to be elderly patients\(^5\). With the increasing aging population, common causes of vision loss such as cataracts, glaucoma, and age-related macular degeneration are on the rise\(^6\). How then, can we justify choosing not to see these patients?

As an optometrist, we take an oath to provide care for all those who seek our services with compassion, and with due regard for their human rights\(^7\). But when we decide to make our patients feel inferior to other patients, based on our perspective of their wealth, we are not only violating our oath, but also
violating the patient’s ethical rights. Let us think about this in terms of the feminist bioethical theory. The feminist theory is grounded in a critiquing of background norms that result in observable and persistent injustices in healthcare.\textsuperscript{8} It is directed against ideas that ignore morally relevant individuals, while highlighting privileged perspectives. When someone as privileged as a doctor chooses to deny service to a patient due to their healthcare insurance, or chooses to treat them worse because of it, then they are choosing to serve only themselves. In the above case, although the patient was not denied service, he was made to feel as though his eye health was not important - all because he was perceived as poor. The feminist bioethical theory would thus classify this situation as a clear injustice towards the patient.

Lastly, treating eyecare as a sellable product leads to poorer quality of care\textsuperscript{4,9,10}. Denying patients eyecare is only one way of negatively impacting your patient’s health. Often, within a given community, there are only a few optometric clinics that accept Medicaid and Medicare coverage. Those few clinics tend to get overbooked and overcrowded with patients who cannot find care elsewhere. This leads to less time allocation to their exams, less thorough eye exams and long wait times that cause patients to leave without being seen. Additionally, doctors are inclined to have a negative bias towards individuals that cannot afford their services. These individuals are frequently seen as “causing their own problems”, “litigious”, “troublesome” and “irresponsible,” although the truth of these claims is conjectural\textsuperscript{4}. In fact, existing studies show that poor individuals are less likely to sue their practitioners than their counterparts\textsuperscript{11}. Furthermore, many negative perspectives that doctors tend to have towards their lower socioeconomic patients are often directly correlated to the barriers they face\textsuperscript{4,9}. For example, patients are more likely to cancel their appointments due to a lack of access to adequate childcare.\textsuperscript{4} Evidence does show, however, a correlation between these biases and the decreased quality of care.\textsuperscript{4} In the case above, we see that the elderly was made to feel like a burden. As he did not speak English, it was imperative we made sure that he understood his medication dosage routine. However, once he was made to feel unwelcome, he stopped asking clarification questions, and did not return for the follow-up exam for his corneal injury. This is not up to the standards of care taught to us as optometrists.

Now, it is important to note that these issues do not apply to all optometrists, nor does it apply to all non-O.D.s. However, it is imperative that we acknowledge this growing gap between eyecare services, and individuals that need it but cannot access it- whether it is due to a negative stigma towards them, or a lack of clinics that serve their needs. When the above-mentioned ethical violation occurred, I made it a
point to discuss my concerns with the optometrist after the patient had left, although I truly wish I had said something sooner. While I understand that certain aspects in optometry must be allocated as market commodities, it is critical to not forget that we are optometrists for the patient, and our patient should always come first. The eyes being a window to overall health, it is vital that we unfailingly live by our professional ethics, and assist those individuals that need our services the most.

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References


