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The History of Optometry

Ethics
The Growth of Ethics in Optometry

Alex Kozlov

Sight is one of the most valuable senses a human being has. Throughout the ages many have been fascinated by how it works and how one can improve it, either during old age or because of various health problems. The profession of optometry finds its roots in the highly technologically advanced countries of Middle East, dating as far back as 700 A.D. with basic research of light and optics. Centuries later, around the 1900's, there finally arose a need in the general population for Optometry to become an independent profession, diagnosing, treating, and preventing eye related health problems. However, along with this push for further eye examinations and treatments came the question of what the eye doctor was ethically allowed to do to a patient, as well as the training that was required to be considered a professional in this field.

Initially optometry was a largely commercialized profession where the focus was on selling commodities such as eyeglasses and hard contact lenses to the general public. As the technology and science in the profession increased, the uneducated could no longer provide safe care and examination. Reputable practitioners began organizing and pushing for protection of the public from the poorly educated and money seeking businessmen that were common in the profession. The direct result of this push was the legislature enacting laws that defined the practice of optometry, and the establishment of the American Association of Opticians in 1898. Only two years later, the association redefined its
standards limiting membership only to graduates of optical colleges, currently practicing opticians, and not people that merely dealt in the sale of spectacles and lenses.

This initial move caused an ongoing process that defined optometry as a medical profession and moved it away from commercialism, and into professionalism. Because of the shift in the diversity of members and a union around a more common goal of professionalism, the American Association of Opticians was able to adopt its first code of ethics in 1908. The newly adopted code emphasized the new direction the profession undertook stating that “optometry is a purely technical profession based on comprehensive knowledge of the mechanisms of the human eye, the skillful manipulation of instruments for its adequate examination, and a knowledge of the properties of light and the relative effect thereon of lenses.”

Even though establishing the first code of ethics was a significant milestone for Optometry, many members of the American Association of Opticians were left with the perception that a more concrete code, that spelled out what was considered ethical behavior for optometrists, was needed. In 1923 there was a new code of ethics proposed but due to large criticism by the members, it was never adopted. The new code was thought too vague, consisting of a “repetition of principles of conduct that are equally applicable to the optometrist, the lawyer, the grocer, and the bricklayer”. The failure to adopt the new proposed code of ethics, and the slow shift away from the original code once again left optometry adrift and under threat
of becoming commercialized. State governments started imposing taxes on the goods, such as spectacles and lenses, that optometrists prescribed to patients. Legislators argued that the profession was once again nothing more than a business of selling goods.

The struggle against commercialism of the profession once again ensued, with the general population not being used to the idea of paying for someone’s advice or a checkup. Because the only tangible things an optometrist was able to provide were glasses and lenses, they were considered as sales people or businessmen. To deal with this reoccurring problem, the American Association of Opticians (now known as the American Optometric Association) adopted a final code of ethics in 1944. This code has now been in effect for over fifty years and has become the cornerstone of Optometry, allowing for further elaborations on various ethical concerns based off newly developed techniques and methods of treatment, but overall remaining a constant guideline.

After the adoption of the final code of ethics, the American Optometric Association helped establish pivotal legislature against commercialism, eventually eliminating most of it from the profession. Even the advertising of ophthalmic goods was successfully restricted in the majority of the states. It was established that Ethics in optometry goes hand in hand with its economical aspects and prevents commercialism where an optometrist just becomes a businessman with a commission for every pair of glasses sold. Profits therefore became directly derived from the professional services rendered based on the education and
skill of the optometrist while the sales aspect was simply written off as a lab expense.

The final code of ethics adopted in 1944 focused not only on defining what constituted the ethical actions of an optometrists, but also on the rights of the patient, and behavioral standards for every optometrist. This was significant because it enforced patient doctor confidentiality in the field, and forced all optometrists to maintain a level of practice up to par with professional healthcare standards. Starting from a simple sales profession, optometry finally reached a level where it was considered a part of the healthcare field. Optometrists are now ethically allowed to diagnose all ocular diseases, treat them, prescribe drugs, prescribe corrective devices, and even perform laser surgery in a large number of the states.

Even with a solid code of ethics, Optometry in the twenty first century faces new ethical questions that remain unaddressed. Currently, one of the major ethical issues in optometry is whether an optometrist has the necessary skills to do laser eye surgery without the supervision of an ophthalmologist. An increasing number of states have been allowing optometrists to carry out the procedure with additional training, but many still refuse arguing additional training is not enough. The debate circulates around the knowledge that an optometrist gains while in optometry school versus the knowledge an ophthalmologist gains while in medical school. This relates to the portion of the code of ethics that states an optometrist must make sure “every step is taken to safeguard the welfare of society” and must “keep the patients
eye, vision, and general health paramount at all times”. Allowing optometrist to do laser surgery could put a patient under risk assuming that optometrist in not qualified enough to conduct the procedure. However, denying an optometrist the right to perform such a procedure could violate a different section of the code of ethics, which states an optometrist must “advance their medical knowledge and proficiency to maintain and expand competence and scope of practice to benefit their patients in all possible ways”.

In today world the ethical issues in optometry have pushed mush further then the clinic itself spilling out into the general population. Complicated questions often arise relating to a patients ability to pay for an optometrists services, lacking health insurance, and third party billing issues with insurance companies. An optometrist is bound by the code of ethics of the profession to make sure that no care is refused to a patient based on their ability to pay. The code has a considerable section that discusses this issue emphasizing that the standard of care should not differ between patient groups based on their method of payment or ability to pay. Often, the medically indigent population feels disenfranchised with the medical community because the doctor fails to advocate for the patient that does not bring him a paycheck.

New healthcare reforms in America promise to address such issues, including Optometry in the new Medicare plan in the works by the presidential administration. Even though Medicare covers only the elderly population, this makes up a significant portion of an optometrists medically indigent patient group.
By allowing Medicare to cover regular eye exams and specialized procedures the patients would be much more likely to manage their eye health better and not prioritize it below other necessities. Enacting such a reform could be a pivotal point for this ethical dilemma in Optometry leveling the playing field for all patients so that all get the best possible care and the upmost attention from an optometrist.

Optometry has come a long way from the initial sales profession it once was. As the scope of practice for optometrists grows, technology is advanced, and new treatments are developed, the code of ethics needs to remain current and able to address the issues that arise from such changes.
Case Studies
Truth Telling in a Clinical Setting

Tonometry Slipup

Case Study:

Jim is a third year optometry student in his first term in clinic. Jim has a good relationship with his attending supervisor, Dr. Melvin. Today Jim is performing a standard vision exam on a patient, Ms. Jones. Jim performed all parts of the exam as he had always practiced, but during BIO Ms. Jones began to tear up and said that her eyes were starting to sting. Jim stopped performing the BIO and re-examined the anterior of the eye with a slit lamp. What he discovered was a large tonometer footprint on the right eye. Jim then realized what had happened… he had forgotten to rinse off the hydrogen peroxide from the tonometer tip before using it and surmised that this was probably the cause of the footprint on Ms. Jone’s eye. Jim is embarrassed by this mistake and now feels he has an ethical dilemma on his hands. How would you handle this situation if you were Jim?

Case Questions

1. What would you tell Ms. Jones after discovering the footprint? Do you have an ethical obligation to disclose the true cause of the patient’s pain? If you deem the likelihood of any serious damage to be extremely low would that have an impact on your decision-making?
As the healthcare professional in this situation, I believe I would have the obligation to tell Ms. Jones of the mistake I made. It does not matter if the likelihood of serious damage is low or not. I am still obligated to tell the patient the entire truth, making sure they understand the consequences of my mistake and should take the proper methods toward treating the injury, eliminating pain, and preventing further injury. Today the standard for all good clinical communication includes truth telling not deceptive reassurance and lies. Law also dictates revealing all relevant information to the patient. This can benefit me as the intern legally later, but could also harm me. Because the error is evident, and it is evident who caused it, the best course of action would be to tell the patient including an admission of fault as well as a sincere apology. The supervisor should be consulted first.

2. What would you tell your supervisor, Dr. Melvin?

I would go to Dr. Melvin first, before I told anything to the patient and explain my mistake, looking for advice on further actions. The supervisor has much more experience in this case study, and therefore has dealt with similar dilemmas previously. His input would be valuable and allow me to assess the extent of the damage my mistake has caused to the patient. In turn, this would help me give the patient all the facts when revealing my mistake, as well as allow me to reveal the mistake properly. There are many courses of action that one could take when revealing a mistake. The first is offering condolences, but no admission of fault. The second is offering condolences, and admitting your fault. The third is offering condolence, admitting a fault, and offering the patient compensation, weather it’s for the damage done, or monetary settlement to prevent a malpractice
lawsuit. The supervisor would be the best person to tell you how to proceed, as well as how to apologize. If there is a risk manager available for the practice, that person should also be sought out for advice, and the best course of action.

The supervisor should be indefinitely involved because this is a person that is on your side and there to help you. As an intern, you are practicing under the supervisor’s medical license, so doing anything that might look bad on the supervisor’s record, such as attempting to cover up a mistake, is not an option.

3. Do you bill the insurance and mark corneal damage on your route slip?

Ethically, an optometrist is responsible for treating any damage he caused by his mistake out of his own pocket or through his malpractice insurance if the amount is too large. The corneal damage should be marked on the route slip so that other physicians in the future are aware of the situation if complications arise. However, the insurance company should not be billed for any treatment regarding the damage caused by the mistake.

4. If you do not have enough samples in your office, do you bill the patient for the drugs required to reduce pain and prevent infection of the eye now that it is compromised?

No, the patient should not be billed for anything regarding the mistake you made. If you do not have enough samples, then either obtain more samples or cover the charge out of pocket for the required prescription.
5. What if the damage was minimal (requiring no treatment and would heal by the end of the day), how would it change your answer to questions 1-3?

No, my answers would not change. The only two ways it is ethical not to disclose relevant medical information to a patient is if they specifically request that you do so, or if puts them in danger (causes suicidal thoughts or depression). Although there are downsides to revealing a mistake to a patient, ultimately it is the right things to do. A patient might loose faith in a doctors ability to practice, become angry, or feel vulnerable. However these consequences are miniscule compared to the consequences an optometrist would face if the patient later found out on their own accord. In the long run, revealing the mistake can lead to a stronger doctor patient relationship, creating a bond of trust that makes the patient feel secure in the doctors hands. The complete opposite can happen if the mistake is uncovered without the doctor letting the patient know.

Doctors are taught to not make mistakes while going through school. However, this is an unrealistic expectation for any human being. No matter how skilled, a doctor is always bound to mistakes in the course of his or her career. When this does occur, the mistake has to be dealt with properly to allow the doctor to regain peace of mind and be able to continue practicing confidently.

The ethically and legally correct courses of action agree in this situation and suggest taking the option to tell the truth. The patient noticed pain during the exam, after an exam procedure was conducted. This is a dead giveaway for the mistake. If I as the intern don’t
tell her about the mistake, she will most likely go to another practice and get a second opinion allowing the other optometrist to see the corneal burn. This will look much worse on my practice, then admitting to a mistake. This is purely from the legal standpoint. However, the ethical standpoint agrees and the optometrists guide to ethics supports truth telling.

6. Although unlikely, what if the damage was enough to require referral to a specialist, what would you tell the specialist?

The specialist would see the patients record, and see the recoded mistake that caused the damage. In my opinion it is better to contact the specialist and give further explanation on the situation, adding a personal touch. The specialist is a healthcare professional, just like you and therefore would have a much better understanding about mistakes in medicine then the patient. There is a large disconnect between the patients and doctors viewpoints when it comes to medical mistakes. Medical professionals are much more likely to understand the mistakes of other professionals, and fell sympathetic as well as try to help. Ethically it is improper for one medical professional to pass judgment or speak negatively of another. Therefore, this would not be a concern for me when informing the specialist.

It is understandable that admitting such a foolish simple mistake can be embarrassing, but this is a much better option then covering it up. It is better for the doctor to realize that they are a human being and prone to mistakes, therefore taking ego and pride out of the situation. If everything is dealt with professionally, embarrassment should not be an
issue. In the scenario it is the intern that makes the mistakes, so this slightly reduces embarrassment. The intern is only in the first year of clinical rotations, and has no experience, as well as no reputation to uphold. Everyone makes mistakes when they are learning, and that’s why optometry school is such a lengthy process containing so much testing and rigor.

7. Add this to the story. Jim tells Dr. Melvin what he has done. Dr. Melvin tells Jim to say nothing to Ms. Jones because of liability concerns. How would this addition to the story complicate the ethical life of Jim? What would you do if you were Jim in this situation?

If the supervisor directly forbade me from speaking about the mistake with the patient, matters would become much more complicated. The consequences of telling the patient would now be much more severe, possible including the loss of my job. If I were Jim in this situation, I would go above the supervisor and speak with someone higher up to get his or her advice. Overall, I don't think that anything an outside person told me would sway me away from my decision of telling the patient. Ethically speaking this is the only correct course of action in this situation, and even if dire consequences follow it must be taken. No one in the field of medicine should be able to prevent you from taking the ethically correct path.

If the supervisor’s only reasoning behind me not disclosing my mistake is that there might be legal ramifications, then I would remind him that the mistake is evident. The chance of it being discovered by other healthcare professionals is large, and that
would make the situation much worse. Also, the patient will need treatment to
correct the mistake, and this would require the use of eye drops and other measures
to prevent further damage. Getting the patient to do this would require either more
lying to the patient and falsifying a condition for which she should take the drugs, or
telling the patient the truth. Falsifying the reason the patient should take drops gets
a doctor into even more dangerous ethical territory.
A 12-year-old male, Mike, comes in to the clinic for his second eye exam ever. The chief complaint is that Mike says his vision has been blurry, as well as consistent headaches. Both started a few days after the initial prescription of glasses six months ago but the patient was told his eyes just needed time to adjust. The symptoms have been getting progressively worse. Upon checking the patient, it becomes evident that during his initial visit, he was given the wrong prescription during dispensing. The patient had been wearing the wrong glasses the entire time, possibly causing permanent damage to his vision, as well as headaches and distress. An FDT was run on the patient and significant field loss was found in both eyes. You are a third year optometry student, and Mike is your patient. However you were not the one that worked with him when he came for his first visit because you are only starting your clinical rotations.

Your attending is a very competent Optometrist, Dr. Creston. Upon looking further into the patient history, you see that he was the one that originally examined Mike the patient during his first visit. Mikes mom tells you that neither she or her son were educated about what should happen after he received his glasses, and didn’t know that his symptoms should have been cause for them to come back in immediately. From this you gather that no patient education took place during the glasses dispensing, as well as during the exam. When the problems initially started,
the mother called the Optometrists office several times, but was reassured by Dr. Creston that Mikes eyes simply needed time to adjust.

How do you go about handling this case? Do you talk to Dr. Creston about the mistake, and alert him that he was the one who made it? Do you inform the people that did the dispensing that they made a mistake? Do you have right to place blame at all? How do you approach Dr. Creston with your suspicion that the patient was not educated about his prescription and this resulted in possibly permanent eye damage?

Do the answers to these questions change if you run further test and find out that Mikes vision is now even more severely impaired, and this was likely due to the wearing of the wrong prescription for the six month period? What actions should you take to ensure patient care from this point on? Do you tell the patient and his mother that the wrong prescription was dispensed? Do you inform them that it was the clinics fault? Do you tell them that the decrease in Mikes vision is due to the wearing of the wrong prescription? Who do you bill to treat the damage that resulted from the wrong prescription? Do you bill the patient for the new, correct prescription?

If you have the option to just tell the patient he needs a new prescription, not shedding light on the mistake, do you take it? What if this is the route that the attending tells you to take when you inform him of the mistake because he is concerned about liability issues. Do you obey the attending?
The Cost of Treatment

Optometry Ethics Case Study

You are a proud owner of a private practice that has been doing reasonably well and things could not be better. Today you have a walk in appointment. It is a 49-year-old Hispanic female, Rochelle, with a chief complaint of blurred vision. She does not have insurance and informs the clerk that she will be paying for the exam in cash. While taking patient history you learn she has never had an eye exam and is a type 2 diabetic. Upon conducting the exam you discover she is in need of a prescription for corrective eye wear and there are strong indications of glaucoma. After informing the patient, you notice she starts feeling uneasy. This feeling becomes more evident when you tell her the cost for the prescription, and she informs you she cannot afford it. Her response is the same when you tell her she will need to come in for a full glaucoma workup. Money seems to be a big concern for her. You suspect she will ignore your suggestion to come in for a follow up appointment because of financial reasons, and in spite of your strong suggestions and warnings about glaucoma. It seems she thinks that you only made the suggestion for a follow up to charge her more money. Upon further discussion with the patient, you also learn that she drove to your practice, and plans to drive back home. Your tests indicate that her vision is well below that of acceptable DMV guidelines.

You have sample contact lenses in stock that match the prescription of the patient. However, they are not FDA approved for overnight wear, and are only good for up to two weeks. The contact lenses are also a few weeks past their expiration date. The practice
does not have any contact lens samples that match the patients prescription, are unexpired, and in stock.

How do you proceed in handling this case? Is it your responsibility to convince the patient to come in for the glaucoma workup? If she cannot afford this, should her standard of care be influenced by the amount of money she has? Do you offer her a free follow up visit? Does the answer to this change if you suspect the a free follow up will lead to her informing others without insurance and money that you do free work and cause a flood of people with similar situations to your practice. Do you call the DMV and inform them of the issue with Rochelle’s vision possibly resulting in her getting the drivers license revoked? Do you give Rochelle the expired trial lenses to prevent her from posing a danger to other drivers on the road during the drive back home? Does the answer to this question change if you suspect she will wear them continuously, and for as long as she can because she cannot afford any other vision correction device? Does her lack of money sway you to treat her differently than a patient with money or insurance?

Case Study Questions:

1: Is it your responsibility to convince the patient to come in for the glaucoma workup? If she cannot afford this, should her financial situation limit the amount of care she gets from your clinic? Do you offer a free follow up visit to do the glaucoma workup?
As an optometrist, it is a part of your code of ethics to not discriminate among patients based on their ability to pay. While this is easily said in theory, it is much harder to implement into practice. The code of ethics states that “It shall be the ideal, resolve, and duty of all optometrists: to strive to ensure that all persons have access to eye, vision, and general health care”. This undeniably makes it your responsibility that Rochelle gets proper medical treatment, either with your clinic or somewhere else.

The amount of money the patient holds should never dictate the standard of care that is given to the person. Some people might argue that giving a medically indigent patient a lower standard of care then a paying patient should be acceptable, and because the care is free the patient should be thankful for anything received.

When Rochelle walked into your office and you accepted her as a patient, you have established a relationship knowing very well that she does not have insurance. Because of this, the potential glaucoma becomes the responsibility of your office. While optometrists are not legally obligated to treat the medically indigent, once an optometrist establishes someone as their patient, that optometrist has to fulfill his oath and make sure the patient gets the upmost care, not matter of the ability to pay. Optometrists operate under an oath to ensure the upmost welfare of their patients.

While the treatment of Rochelle will surely become a financial burden on the private clinic, the economics of the situation should not influence the amount of care and attention you as the doctor give your patient. This lies at the heart of the patient doctor
commitment that you make when taking on a new patient. The healthcare field is not simply an economic market with money to be made from the sick. Becoming a healthcare professional often means taking on obligations to serve the less fortunate, even if not required by law.

The diagnosis of possible glaucoma is very serious, and can be frightening for a patient to face alone. In a normal situation the optometrist would be there for the patient, and help walk them through the diagnosis, possible treatment options, as well as the prognosis of the disease. However, in the case of the medically indigent, the optometrist in less inclined to do this seeing it as a waste of time that could be spent providing care to his paying patients. This often results in the optometrist spending much less time doing patient education with the indigent, causing them to feel unwelcome and making them feel like a burned on the very busy doctor. This disconnect in the patient doctor relationship can potentially be very harmful to the patients confidence in the doctors care about him or her. In the case of Rochelle, you as the doctor have to realize this and make sure to undertake the full responsibility of giving her as much time as a paying patient, making her feel comfortable and sure of your ability to care for her. Optometrists must indefinitely refrain from the temptation to provide a lesser standard of care for the medically indigent.

In the end, you as a doctor should either offer the patient a free follow up visit, refer them to a free clinic where they can get a full glaucoma workup, or negotiate something along the lines of a payment plan that would help cover the costs of treatment.
Does the answer to this change if you suspect the a free follow up will lead to her informing others without insurance and money that you do free work and cause a flood of people with similar situations to your practice?

Initially this might seem as a silly assumption, but realistically speaking this is very possible depending on the location of the optometrists practice. Some optometrists face the challenges of having a lot of patients that either have no insurance, or are covered by an incompetent government program such as Medicaid. This is tough for any practice to handle, especially because the government compensation that Medicaid provides to the optometrists is often much less then that of the actual cost of the procedure.

Looking strictly at the situation in this case study, the answers to the first question can in no way change based on your assumptions that this might cause an influx of medically indigent patients to your practice. The reality of this situation is that, even though you treated Rochelle, you are not obligated to treat every medically indigent person that walks into your practice. Ethically speaking, an optometrist should take on a few indigent patients, based on what the resources of that optometrist permit him to do. However, beyond that the optometrist can do nothing more for that population and has therefore fulfilled his duty as a healthcare professional to the community.

2: Do you call the DMV and inform them of the issue with Rochelle’s vision possibly resulting in her getting the drivers license revoked?

This is a very difficult question to answer, and involves a lot of variables that you as the optometrist have to take into account. First of all, this directly conflicts with the concept
of doctor patient confidentiality. When you became an optometrist you took an oath to “hold as privileged and inviolable all information entrusted to me in confidence by my patients” as stated in the optometric oath. This along with the enforcement of patient privacy acts like HIPPA suggests that you cannot take action against the patient, even if you believe her to be in violation of the DMV guidelines for safe driving. However, even though initially it appears your hands are legally ties in this situation, in reality they are not. A part of the ethical code for optometrists also requires them to serve the community not only as medical professionals but also as upstanding citizens, and to protect the well being of the community. This shows that even though patient doctor confidentiality is important, it is not always of the highest priority when the well being of the community is considered.

Many states have laws that require you as a healthcare provider to report information about your patients that might suggest they are in violation of things like DMV driving standards. If this were in fact the case in your state, you would be committing a crime by choosing to not report Rochelle. However, while laws might dictate this to be a clear case in some situations, this is not always true. No matter what the law in your state of residence says, the patient should always be consulted and informed of this before any action is taken. Often it is enough for the doctor to consult with the patient, inform them of the dangers they pose to others and this will deter them from driving. While this is the case in most situations, there are always exceptions. If the law requires the optometrists to report the patient, then the patient should be informed of this as well. In order to preserve the patient doctor relationship, the optometrist should reiterate to the patient that
law requires this and there is nothing he can do. The optometrist should also note that the patient will have the opportunity to prove his or her driving skills in a state administered test, and if in fact there is no problem with the patient's driving ability then their license will not be revoked.

Ultimately the situation of whether or not to report your patient to the DMV relies on a risk assessment done by the optometrist, as well as the legal constraints that particular practice abides by, based on its location in the United States. In the case of Rochelle, you as the optometrist would have an ethical obligation to consult her, telling her she should not drive without getting corrective vision. Beyond that there is not much you can do because reporting her to the DMV would simply force her to do a driving test at a later point in time, by which she will already obtain corrective devices for her vision, either from your practice as an indigent patient, or at a cheaper location.

3: Do you give Rochelle the expired trial lenses to prevent her from posing a danger to other drivers on the road during the drive back home?

Giving the patient the expired contacts presents another dilemma for you as the optometrist. On one side of the argument you face the fact that she is medically indigent, and therefore cannot afford the glasses. By giving her the expired contacts, you are abiding by a lesser standard of care, which is never acceptable once you take on a person as your patient, no matter their financial status. However, the other side of the argument is that by not giving her any sort of corrective vision device before she leaves your office, you run the risk of her posing a great danger to other drivers on the road.
Ultimately your decision should depend on weighing how safe it is for the patient to wear the expired contacts, versus how much of a danger she would be without them. If I were in the optometrist’s situation, I would provide the patient with the contact lenses. The fact that they are expired is not a large concern because it is only by a few weeks. Because her vision is well below DMV guidelines, and she is complaining of a constant blur I would judge that she possesses a great danger to all drivers on the road, as well as to herself. My oath to protect the health of my patient and the community would drive me to provide her with the contacts. Alternatively, I would also ask if she had anyone in the vicinity that could come and pick her up instead of her driving at all.

4: Does the answer to this question change if you suspect she will wear them continuously, and for as long as she can because she cannot afford any other vision correction device?

This suspicion would completely alter my perception of the situation. If the patient did not schedule a follow up appointment, and I suspected she would violate rules for proper contact lens use, then I would not provide her with them. Wearing contacts for longer than one is supposed to, as well as not taking care of them properly can cause a great multitude of problems for the patient. The lens becomes a breeding ground for bacteria, which results in an imminent infection of the patient’s eye. This would then require a very expensive treatment plan, that is likely unaffordable by Rochelle. Ultimately without the treatment the infection would cause further strain on Rochelle’s vision and with the possible glaucoma factor result in almost total blindness.
Ethically, I as the optometrist would be acting on the code of ethics principle that puts my patient’s health and well being above all else. The primary principle of medicine is to first do no harm. By giving the patient these contacts, I would ultimately be causing her great harm and possible loss of sight. The fact that she is driving without corrective vision is overshadowed by this factor. In this case I would strongly suggest she have someone come pick her up, but I would be powerless to stop her from not following my advice if she chose to ignore it.

5: Does her lack of money sway you to treat her differently then a patient with money or insurance?

This question is thoroughly addressed in the above answers. Because you chose to accept Rochelle as your patient knowing she was medically indigent, it becomes your responsibility to take care of her eye care needs or at least make sure she has a way to have them taken care of. The economic side of things should never influence a healthcare professionals quality of care for their patient.
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