Review Article

Ethical Dilemmas in Contemporary Ophthalmic Practice in Nigeria

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ABSTRACT

Background: Ethics, as a branch of both philosophy and theology, is a systematic study of what is right and wrong with respect to conduct and character. As an intellectual discipline, ethics seeks to provide good reasons for our moral choices. **Aim:** The aim was to discuss common plausible clinical scenarios that pose ethical questions in typical ophthalmic set-ups in Nigeria and suggest modalities of resolving them. **Methods:** Involved extensive literature search on ethics and medical jurisprudence. **Result:** There is hardly an area in medicine that does not have an ethical aspect. For example, there are ethical issues relating to abortion, organ donations, birth control, euthanasia, etc., Ethics in Ophthalmology have not been the focus of scholarly articles particularly in our African environment. Yet there is increasing consciousness of patients' right to self-determination that cuts across all areas of human endeavors. **Conclusion:** Ethics, and not the law, establishes the ultimate standard for evaluating conduct. Still, there is a moral obligation to obey the law, and thus ethical analyses need to take into account the relevant statutes and court decisions.

Keywords: Ethics, Nigeria, ophthalmology

INTRODUCTION

The first code of medical ethics was published in the 5th century although anecdotal reports have traced the origin of medical ethics to antiquity. The Hippocratic Oaths, antedated by early Christian teachings, have served as framework within which doctors confined their practice. In the medieval and early modern period, the field is indebted to Islamic, Catholic, and Jewish medical ethics and moral theology.[1] The field continues to evolve at varied pace being moderated by religious inclinations, culture, legal status, and societal complexities in different regions of the world.[2-5] To cause no harm and transparent objectivity in clinical decisions appear common to medical ethics and code of conduct across the globe. Helsinki Declaration has attempted to harmonize the code of research ethics for universal applicability.[6,7]

In Nigeria, there is growing awareness on the need to protect the right of clients accessing health facilities occasioned by increasing number of litigations.[8,9] As we approach the twilight of Vision 2020, a global initiative that seeks to significantly reduce global blindness burden, it has become imperative to stress issues that border on patients' right and medical jurisprudence, especially relating to eye care. The Nigerian Medical and Dental Council have continued to sanction medical doctors who violate the code of medical and dental practice. Ophthalmologists have also been summoned to answer queries on patients they solely or co-managed. And where found wanting, they have been disciplined according to established guidelines. The practice of obtaining written informed consent from patients or family members (where the patients are minors or incapacitated) before surgeries or other clinical procedures is common across medical disciplines in Nigeria.[10] Other parts of medical ethics are yet to receive this degree of national awareness. While moral burden posed by medical ethics is overwhelming, there are several challenging scenarios,

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some examples given below, where decisions have to be made between morality and reality.

OPHTHALMOLOGISTS' CODE OF ETHICS

American academy of ophthalmology

Codes of ethics describe moral virtues as well as moral duties. A virtue is any quality of character that is valued. A moral virtue is a quality with moral value.[11] Other moral qualities that are valued by ophthalmologists are kindness, charity, and a commitment to ending unfair discrimination. One of the ways in which professionals have traditionally governed their behavior is through a code of ethics. The American Academy of Ophthalmologists (AAO) has distinctly shaped the professional conduct of many ophthalmologists across the globe through a code of ethics.[12] Modern codes of ethics, as laid down by AAO, have a direct debt of gratitude to the Hippocratic principle. Some of these are enumerated: The performance of medical or surgical procedures shall be preceded by appropriate informed consent, an ophthalmologist shall respect the confidential physician-patient relationship and safeguard confidential information consistent with the law, fees for ophthalmological services must not exploit patients or others who pay for the services, it is the responsibility of an ophthalmologist to act in the best interest of the patient, it is the responsibility of the ophthalmologist to maintain integrity in clinical and basic research, the responsibility of the ophthalmologist extends not only to the individual but also to society as a whole, and communications to colleagues or public must be accurate and truthful.[12]

International council of ophthalmology

This International Council of Ophthalmology (ICO) document comprises a set of moral principles and standards, an off-shoot of the ethical code of the World Medical Association, to guide the behavior of ophthalmologists within their professional domain.[13] The guidelines reflect the ideals to which ophthalmologists should aspire as members of a specialist branch of the medical profession and as socially responsible members of their respective professional societies. The ICO ethical guidelines consist of a general principle from which subsequent standards emerged.

International council of ophthalmology general principle

Good patient care depends upon medical and technical expertise, clinical decision-making, communication and teamwork, and health advocacy. The ophthalmologist ought to ensure that patients are treated with dignity, honesty, and integrity, and must act in the best interest of the patient at all times.

International council of ophthalmology ethical standards

The ophthalmologist ought to

- Act in the best interests of his/her patient
- Put a patient's health and care above all other considerations
- Provide prompt help to persons whose life or health is endangered by disease or accident within their scope of competence
- Treat patients without discriminating on the basis of age, gender, ethnicity, sexuality, nationality, insurance status, disability, religion, lifestyle, or culture
- Ensure the privacy of the patient, and maintain confidentiality in all aspects of the patient's treatment within the confines of the law
- Obtain informed consent from the patient for all interventions
- Provide the patient with truthful and accurate information about the state of the patient's health.

ETHICAL DECISION-MAKING

Hypothetical five clinical scenarios that posed ethical questions in typical ophthalmic set-ups in Nigeria have been mentioned below. Attempts have been made to discuss them and proffer solutions individually and collectively.

Confidentiality

Confidentiality is central to trust between doctors and patients.[14] The principles of confidentiality in modern medical practice are ethical. In order to maintain trust in the doctor-patient relationship confidentiality should be maintained unless disclosure can be justified by an interest which outweighs the patient's interest.

The original source of a doctor's duty of confidentiality is the Hippocratic Oath. Regarding confidentiality Hippocrates said: "Whatever, in connection with my professional practice or not in connection with it, I see or hear in the life of men, which ought not to be spoken of abroad, I will not divulge, as reckoning that all such should be kept secret." The obligation of confidentiality spoken of here is not absolute; it is up to the doctor to decide what information "ought not to be spoken abroad." Another Oath of confidentiality is the declaration of Geneva which says: "I will respect the secrets confided in me, even after the patient has died." Here, however, the obligation is absolute.[15] These are two sources of a doctor's duty of confidentiality which, although they differ in the extent, both highlight the importance of respecting the confidentiality of patients.

Hypothetical case history

A 25-year-old newly married lady presented to her ophthalmologist with visually significant developmental cataract in her right eye. Preoperative assessment and investigations reviewed she was HIV positive. After counseling, she was told about her status. She earnestly requested that the information should be kept confidential between the ophthalmologist and herself.

Ethical question from this case

- Should the ophthalmologist oblige the patient and in the process put other theatre staff, who may not take extra precaution during surgery, at risk?
- Often there are designated surgical instruments for HIV positive patients in some centers, should the ophthalmologist not inform the staff in the autoclave room in preparation for this thereby putting other patients at risk? Should the ophthalmologist inform the husband for early commencement of anti-retroviral therapy if found positive?
- Should the ophthalmologist discuss this case at the departmental seminar so as to follow laid down departmental protocols on such cases?
- Should the ophthalmologist inform the hospital management in line with Health Ministry's directive to keep track on the yearly epidemiological survey on HIV infection?

Proffered solutions

These and more are ethical dilemmas faced by ophthalmologists. A situation in which two or more choices are morally justifiable, but only one is capable of being acted on at a particular time, represents a moral dilemma. Different people will give different answers to these questions. Some will say confidentiality should not expose others to danger while others will claim that it is not the ophthalmologist's business to get involved with family matters and issues that belong to the state government. At either end of the argument, patient reserves the right to sue if confidential information leaks out and the ophthalmologist could be sanctioned for flouting government directives. In the situation presented, adequate counseling can help allay fears and anxiety in this patient. This could make her open up and willing to share their concealed problem with her spouse who stands to benefit from early screening and disease curtailment if found positive of HIV. A patient who perceives the doctor to be empathic, concerned and attentive is likely to gain the necessary confidence to share nagging problems.[16]

Universal health

In the conceptual framework of bioethics, the questions concerning access to healthcare fall primarily under the principle of justice (i.e. fairness, entitlement to and equitable distribution of resources).[17] Globally, in the face of the widely sung principles of Primary Health Care which advocated equity in the distribution of health resources among other things, access to healthcare services is far from equitable. This legitimately raises the question of justice.

National Health Insurance is a laudable scheme that provides subsidized health services to Nigerians. But this only meets the needs of a few employees of private and government agencies with the majority of the population having to pay fully for healthcare. So what happens when the uninsured get sick and ends up in the emergency unit of a health facility? Each year, in the United State, federal, state, and local governments, along with numerous charitable individuals and organizations, provide billions of dollars to support healthcare for the uninsured. But this care often is of lower quality and results in poorer outcomes than that provided to those who have health insurance coverage.[18] In Nigeria, efforts are made by state and federal governments to offer selected health services to members of the society adjudged disadvantaged, but such gestures are yet to yield desired results. The nagging question: How are the health needs of the vast uninsured Nigerian population met?

Hypothetical case history

A 45-year-old civil servant was sacked from work on account of poor vision in both eyes. On examination, the ophthalmologist discovered that he had end-stage glaucoma in both eyes. For maximum control of eye pressure, he was placed on triple therapy of timolol, latanoprost, and brinzolamide following his rejection of surgical option. Unfortunately, he could not afford the costs of latanoprost and brinzolamide, so he continued on timolol alone. This was not enough to reduce the eye pressure. National Health Insurance scheme did not cover these expensive drugs.

Ethical question from this case

- Should everyone be entitled to National Health Insurance policy that guarantees a basic "minimum eye health care" tailored to the diagnosis of the attending ophthalmologist?
- Should the ophthalmologist refuse to attend to him on account of rejecting surgical intervention yet unable to afford essential drugs?
- To what extent can an ophthalmologist in private practice offer free services?

Proffered solutions

Poverty is endemic in the third world. This may have engendered the polygamous marriage of ignorance,

poverty and disease in the developing nations. There is a concerted effort by Nigerian government to meet the health needs of indigent and vulnerable members of the societies. Unfortunately, these efforts have been a drop in the ocean in the face of poor health indicators released by World Health Organization.[19] Many patients in Nigeria and other developing nations are at the mercy of nongovernmental organizations (NGOs), philanthropists and free-will donations. In the example of the civil servant given above, there is a limit to which a Nigerian ophthalmologist in private practice can offer services free amid exorbitant overhead costs to keep practice afloat. In well-established government hospitals in Nigeria, there are departments of medical social health workers saddled with the responsibility of attending to patients who need social and financial supports and finding the means of doing so. This patient can be referred to such centers for attention. There are thriving societies among those with chronic medical conditions and glaucoma society is one of them. This patient could be encouraged to join a glaucoma society which might enable him rub mind with similar patients and access drugs at cheaper rates.

Who operates?

Surgeries are performed by trainee surgeons during skill acquisition. Often, the outcome is less satisfactory than when an experienced surgeon carries out the same surgical process. With the availability of computer simulation and trainer's supervision, complications encountered on the basis of inexperience by trainee surgeons are being minimized in developed countries.[20-23] In most training ophthalmic centers in the developing countries, trainees have unduly prolonged learning curve occasioned by low surgical volume, inadequate supervision and nonavailability of wet-lab materials. Eye camps are organized to source for surgical cases with trainee ophthalmologists expected to meet collegiate requirements on such occasions without monitoring by experienced surgeons. The camp patients not being aware of the competence of these doctors offer to have their eyes operated with often grave consequences.

Hypothetical case history

A Local Government Chairmanship aspirant sponsored a cataract camp to boost his popularity and increase his electoral fortune in a coming election. Staffers of Ophthalmology Department of a Teaching Hospital were invited.

Ethical questions from this case

- Are patients entitled to choose their surgeons despite the surgeries being offered free?
- Patient being entitled to information regarding his treatment, should he be told that a trainee ophthalmologist would carry out the operation? Should a trainee who is just learning be allowed to operate unsupervised? When is a trainee allowed to operate on his own without supervision?
- Should eye camp be a training ground for trainee ophthalmologists, especially when such surgical expeditions are carried out with little or no supervision?
- Who bears the responsibility of untoward surgical outcomes in cases where trainee surgeons operate without the permission of the patient? Technically who is responsible for the surgery and its complications? The trainee or the supervising surgeon?

Proffered solutions

Medical literature is quiet about this matter: who operates? Possibly because majority who bears the brunt of poor surgical outcomes performed by neophyte surgical trainees are the very poor harvested from eye camps. But it continues to be a moral burden to leave innocent eyes in the hands of poorly supervised, at times no supervision, ophthalmic trainees. A trainee is only responsible for his action if he does anything outside his competence or what he has been taught to do by his trainer. A trainer is technically liable for ethical breaches of a trainee working under him, being failure of supervision.

In Nigeria, Anecdotal reports of avoidable complications resulting from incompetent trainee eye surgeons are not uncommon. Given the choice, patients are best positioned to choose who operates them. The reality remains that trainee ophthalmic surgeons need patients to operate on. But the learning curve ought to be made less steep through adequate wet lab simulation and proper supervision.[24] In eye camps, patients should be made to know their surgeons in the spirit of fairness and be given the opportunity to choose their surgeons. Adequate patient selection that ensures trainee surgeons operate on those advanced in age say 70 years, with much reduced physical activities, appears reasonable. Again in cases of bilateral cataract requiring surgical interventions, a trainee may operate one eye while an experienced surgeon performs surgery on the other eye to give the patient the benefit of at least a good eye. Complicated conditions such subluxated cataract, pseudo-exfoliation syndromes, poorly dilating pupils, among others, should be reserved for the experienced surgeon. This underscores the importance of thorough preoperative workup even at eye camps.

Consent at all times?

Primum nonnocere (first do no harm is) is contained in the Hippocratic Oath. Issues of patient autonomy,

transparency, and shared decision-making have increasingly come to the forefront of medical practice.[25,26] Consequently, the duty and responsibility of obtaining valid informed consent has come to embody the shift towards a more holistic patient-centered paradigm of care. There are occasions where patient may not be available to grant consent due to severity of illness and relations may not also be available to stand in the gap yet vital actions need to be expedited to save life and perhaps cost.

Hypothetical case history

An 8-year-old boy presented with a stick injury on the right eye sustained while working on the farm. The boy presented 5 days later with dense corneal exudates which precluded thorough penlight and slit lamp examination. The ophthalmologist took consent for examination under anesthesia and wound debridement. However, lack of funds hampered further management until some members of staff contributed money to offset the theatre bills.

Ethical questions from this case

- On the table, the ophthalmologist noticed that the entire corneal had melted with viscid full-chamber hypopyon and patient would benefit more from evisceration. Should the ophthalmologist go ahead with evisceration despite lack of consent to do so?
- The ophthalmologist sought a fresh consent for evisceration, but the parents declined. In whose interest should the ophthalmologist act? The patient or the parent?
- Based on the poor financial status of the parents, it is unlikely they could afford to pay for second theatre session, should the ophthalmologist carry out evisceration and reduce that chance of disease progression to panophthalmitis and perhaps systemic spread?

Proffered solutions

Consent should be taken at all times. Emergencies should not preclude detailed and well-informed, preferably written consent in the presence of another family member or acquaintance. Clinical photographs or submissions of another patient who had same or similar ophthalmic problem may allay fears and encourage patient in decision-making. No clinical procedure is considered too small to warrant adequate consent. The special challenge posed by illiterate patients can be overcome by prepared consent forms in local languages such as Yoruba, Ibo or Hausa. Such patients can then be made to thumbprint to denote affirmation. In certain cases, especially involving loss of a part of the body, like evisceration, regular consent form should be modified to suit that circumstance emphasizing that a part of the body will be sacrificed.

To be blind or to die?

There exists an ethical debate among three competing paradigm of vitalism, sanctity of life, and quality of life. Vitalism demands that human life is an absolute value, and it should be preserved whenever possible, regardless of the circumstances. The paradigm of sanctity of life argues that a person must not end the life of another innocent human being. The last paradigm, quality of life, assesses whether or not the patients quality of life is worthwhile in order to receive treatment. To be blind or to die? Where patient stays between this undesirable bipolar spectrum is a dilemma modifiable by peculiarities of our African settings. Religious inclinations and perception of life is likely to modify patients' choice in our environment. Poverty, claim of supernatural causes to pathologic situations and dearth of material and human resources for optimal medicare have the tendencies to also influence a patient's choice.

Hypothetical case study

A 2-year-old girl and the only child of an ageing couple presented with bilateral advanced retinoblastoma. By the ophthalmologist's assessment, the chance of survival is 50:50 if the child has immediate bilateral prompt enucleation. Alternatively, chemo-reduction and radiotherapy could be attempted to preserve the less involved eye with a much-reduced chance of survival. There were no national policies for financial assistance on such cases.

Ethical questions from this case

- What is the best decision for this child with regards to preserving an eye but jeopardizing chances of survival or vice versa?
- Patient not being entitled to treatment under National Health Insurance scheme, what does the ophthalmologist do if the parents do not have the resources for treatment? Discharge the patient?
- If patient defaults and comes back with fungating orbital masses and both eyes requiring mandatory enucleation/exenteration, but the parents insisting on salvaging an eye, what should the ophthalmologist do?

Proffered solutions

To live without sight or to die is a choice that at times presents itself to the patient. Whatever is the patient's choice, the attending ophthalmologist in this case ought to provide sufficient information to guide rational decision by the patient's parents. Euthanasia is controversial with varying acceptability from nation to nation and from region to region within some

nations. In Nigeria, the maxim: "when there is life there is hope," may make patients opt for what might be termed "ophthalmic Euthanasia." That is the choice that prefers life than the loss of sight. Sadly, however, because of late presentation, the decision to sacrifice sight does not yield the much-needed result, and both sight and life are invariably lost.

FACING ETHICAL DILEMMAS IN EVERYDAY OPHTHALMIC PRACTICE IN NIGERIA

Consulting existing professional statutes

The ICO and AAO ethical guidelines consist of a general principle from which related standards evolve. The standards taken together are intended to represent comprehensive guidelines to which practitioners might refer when confronted with professional or ethical dilemmas and to act as a benchmark by which to judge behavior in professional matters. In response to eventualities, standards may be added over time, in tune with local laws and peculiarities, but the principles remain immutable. In Nigeria, Ophthalmological Society of Nigeria (OSN) strategic plan-Vision for the Future-Nigeria, has succinctly laid precepts on Ethics and Professionalism to be followed by Nigerian ophthalmologists.[27]

Ethics committees

Hospital Ethics Committees, composed primarily of healthcare professionals and others like clergy, may occasionally have to convene to decide complex matters. These bodies also decide on researches to be conducted on human subjects for appropriateness to ensure the sanctity of human life. Ethics committees are becoming increasingly useful resources to patients and health care providers. Institutional ethics committees and legal consultation services can clear up a great deal of the misunderstanding that prevents ethical problems from being satisfactorily resolved.

CONCLUSION

Ophthalmology, and indeed medicine, is a moral discipline, and its practitioners have special moral obligations, including, but not limited to, promoting the welfare of patients, protecting them from harm, and respecting their right of self-determination. The challenges have remained making rational choices between clinical scenarios which may not skew toward the patients; the existing ethics appears to protect in that circumstance. Fortunately, the OSNs strategic plan-"Vision for The Future-Nigeria" is a reference document that guides the Nigerian ophthalmologist's path towards preserving and restoring vision.

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