



BRITISH
ORTHOPTIC
SOCIETY

Rules of Professional Conduct and Code of Ethics

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Introduction

The Health Act 1999 bestows the status of profession on orthoptics and automatically carries the statutory requirement to regulate professional practice for the protection of patients accessing the service.

The title 'orthoptist' is protected by law and can only be used by persons who have successfully completed a course leading to a diploma (DBO) or degree in Orthoptics [BSc (Hons) Orthoptics or BMedSci (Orthoptics) (Hons)] or an equivalent qualification and who are eligible for and hold Health Professions Council registration. A registered orthoptist holds the status of a professional.

These Rules of Professional Conduct and Code of Ethics are produced by the British Orthoptic Society and will be reviewed on a regular basis to assist members of the profession in keeping up to date with changes in legislation and health care policy.

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November 2003*

Rules of professional conduct: ethical, moral, legal and professional considerations for orthoptists

This document sets out for members and student members of the British Orthoptic Society the relevant ethical, moral, legal and professional considerations that underpin the reasoning of the Rules of Professional Conduct. It should be referred to as and when appropriate.

The purpose of these rules is to promote, maintain and disseminate the highest standards of behaviour expected of orthoptists and orthoptists under training as members of the health care profession. As a result, the good standing and reputation of orthoptic professionals working within their defined scope of orthoptic practice will be enhanced. A breach of such rules could result in a formal complaint and a finding of serious professional misconduct. The orthoptist should also appreciate the significance of professional self-regulation and uphold the principles and practice of clinical governance.

The ethical background to these rules is based on established philosophical principles of patient autonomy, beneficence and non-maleficence and the professional duty of care.

In summary, the orthoptist has the responsibility to ensure that:

- The autonomy of each and every patient is recognised and accepted.
- The consent and involvement of the patient in the treatment is obtained (or, if not that of the patient, a responsible authority) and recorded.
- The treatment and advice given is of a competent standard, evidence-based, clearly explained and intended to benefit the patient.

Rules of professional conduct: statements

Rule 1 Scope of practice

Registered orthoptists shall only practice to the extent that they have established, maintained and developed their ability to work safely and competently, and shall ensure that they have appropriate professional liability cover for that practice. A duty of care arises when the patient is assessed and treated by the orthoptist.

Rule 2 Relationships with patients

Registered orthoptists shall at all times recognise, respect and uphold the rights, dignity and autonomy of every patient and the patient's role in the therapeutic process. They shall establish the name under which the patient wishes to be known, and they shall also introduce themselves formally to the patient, informing the patient of their rank and the name under which they wish to be known.

Rule 3 Confidentiality

Registered orthoptists shall ensure confidentiality and security of information acquired in a professional capacity and shall promote the dignity, privacy and safety of all patients. A duty of confidence arises when the patient shares information with the orthoptist.

Rule 4 Relationships with professional staff and carers

Registered orthoptists shall communicate and cooperate collaboratively with professional staff and other carers in the interests of the patient and with the patient's consent, and shall avoid inappropriate criticism of their colleagues.

Rule 5 Duty to report

Registered orthoptists have a duty to report, to an appropriate authority, any circumstances that may put patients, others, or themselves at risk.

Rule 6 Personal and professional standards

Registered orthoptists shall adhere at all times to personal and professional standards that reflect credit on the profession. They must not engage in any criminal, unprofessional or any other unlawful activity or behaviour. In addition, behaviour, approach and dress should not cause offence to the patient or carer.

Rule 7 Advertising

Registered orthoptists shall ensure that advertising in respect of their professional activities is accurate and professionally restrained.

Rule 1 Scope of practice

Registered orthoptists shall only practise to the extent that they have established, maintained and developed their ability to work safely and competently, and shall ensure that they have appropriate professional liability cover for that practice. A duty of care arises when the patient is assessed and treated by the orthoptist.

1.1 Scope of the practice of the profession

Orthoptics is an applied science – the study of the visual system – and includes its development, binocular interaction and ocular motility, with an understanding of the neuro-anatomy and physiology that underpin this. It therefore possesses its own knowledge base, its own educational methods and practical application based on that knowledge, supported by the best available evidence. Orthoptists should be reflective and be able to operate as independent and innovative practitioners, constantly acquiring further knowledge and skills to permit effective and efficient practice in a constantly changing health care environment. In addition, they should act as independent autonomous professionals with the ability to contribute primarily to the advancement of the profession through research. A profession's scope of practice encompasses those areas for which its members are educated, have a specific level of competency, and are insured to provide. The overall scope of the orthoptic profession encompasses all individual orthoptists' scopes and set the outer limits of practice for practitioners. The breadth and scope of orthoptics encompasses:

- The age-span of human development from neonate to old age.
- The ability to diagnose and recognise the association between specific defects of binocular vision, ocular motility and visual function to other general and neurological conditions.
- Working with individuals who present with complex and challenging problems resulting from multi-pathology illness.
- Health promotion and early identification of problems in the form of screening.
- Knowledge of the management and treatment of ocular problems associated with abnormal development such as retinopathy of prematurity, amblyopia and strabismus.
- The therapeutic management and treatment of ocular problems associated with recovering conditions such as head injury and stroke.
- Treating ocular complaints caused by deteriorating conditions such as multiple sclerosis.
- The management of individuals with ongoing conditions such as diabetes or thyroid problems.
- A broad range of settings including the acute and primary care sector, private sector, schools and nurseries.
- An understanding of the health care issues associated with diverse cultures within society.

1.2 Scope of the practice of orthoptics

Individual orthoptists practise within their own individual scope. This may be defined in general terms by some of the following:

- Occupational role (e.g. researcher, clinician).
- Sector (e.g. NHS, higher education, private practice).
- Environment (e.g. community, hospitals).
- Client group/specialty (e.g. specialised paediatrics, stroke patients, low vision aid groups, people with learning difficulties, glaucoma screening, vision screening).

More specifically, members need to consider their individual scope of practice in relation to individual patients or circumstances. When presented with a patient, the orthoptist should ask the following questions before proceeding:

- Can I justify the decisions that I have made during the assessment? In other words, is the decision evidence-based?
- Can I identify the most appropriate approach for the patient?
- Do I have the correct balance of skills, knowledge and experience to be competent in my chosen approach?

By considering and answering these questions, orthoptists not only identify and determine the limits of their competency, but also demonstrate an understanding of the scope of the profession of orthoptics. The individual is also acknowledging cross-professional boundaries and demonstrating an awareness of other approaches that may be more beneficial to the patient, including referral to another orthoptist or specialist. This approach ensures that every interaction is a learning experience that will not only inform but may also change and develop that individual's scope of practice.

As an orthoptist develops skills in a particular area, there will be an inevitable diminution of skills in another area of professional work. However, providing that the orthoptist can continue to answer the questions raised above, safe and effective practice in the best interests of the patient is ensured.

1.3 Competence and continuing professional development

Members of the British Orthoptic Society have undertaken an initial qualification that has been recognised by the professional body and by the Health Professions Council. The Health Professions Order in Council sets out as an underpinning principle the need to maintain competence to ensure public confidence in professionals. This requires that the practitioner has achieved a certain level of competency in order to ensure safe, effective and beneficial practice. The profession, and health and social care, are subject to ongoing and rapid change. Orthoptists must keep up to date and actively engage in a constant process of learning and development. They are personally responsible for actively maintaining and developing their personal professional competence, and have a responsibility to the continual development of the profession through critical evaluation, audit and research. If research is undertaken, the orthoptist must address the ethical implications and take responsibility for the dissemination of findings in order to inform and change practice.

Thus the integration of continuing professional development into every day practice directly benefits the individual and, in turn, benefits patients and the orthoptic service. Continuing professional development is a requirement of continued practice, and activities should be planned according to the individual's learning needs and recorded in their personal portfolio. As part of this process, orthoptists should consider their personal and professional development and translate this into realistic annual objectives with a proposed implementation plan. Further information regarding continuing professional development can be found in the Society's Continuing Professional Development portfolio.

1.4 Duty of care and civil liability

When a patient is assessed and treated by an orthoptist, the legal and professional 'duty of care' towards the patient is established immediately. The orthoptist has a responsibility to ensure any intended therapeutic intervention will be of benefit to the patient. This requires orthoptists to keep up to date with evidence-based practice in their areas of practice and expertise. This evidence may be in the form of professional standards and guidelines, audit findings or research findings which, following rigorous reviews, are robust enough to inform best practice.

Members should be aware that they have a common law duty of care to their patients, and that a breach of this duty may result in a civil claim for damages from the patient. The duty automatically arises whenever a practitioner offers to give professional advice or treatment. A breach of duty of care to the patient may give rise to a claim for damages for negligence from the patient. A breach of duty may be tested as follows:

'The test is the standard of the ordinary skilled man exercising and professing to have that special skill. A man need not possess the highest expert skill at the risk of being found negligent. It is a well established law that it is sufficient if he exercises the ordinary skill of an ordinary man exercising that particular act.'

Bolam v Friern Hospital Management Committee [1957]

The test was modified slightly in the more recent case of *Bolitho v City and Hackney Health Authority* [1993], in relation to its use on establishing the cause of the breach. It is for the patient to prove that the damage was caused by the practitioner's negligence. In *Bolitho* it was held that (where the Bolam test is applied) the practitioner must demonstrate that the body of professional opinion relied upon to defend the claim has a logical basis, and that the professionals advocating its use had considered the relative risks and benefits to reach a defensible conclusion.

In the majority of negligence cases, the defendant is successful by showing that distinguished experts in the relevant field consider the treatment in question to be appropriate.

1.5 Professional liability insurance

Any health care practice has its risks. It is therefore important that any risks are covered by adequate insurance. In the case of orthoptists, their employer covers them vicariously. However, the level and extent of that vicarious responsibility should be established at the start of employment. It is the responsibility of the practitioner to be aware of what cover, if any, is offered. For orthoptists in private practice, it is usual for the practitioner to be sued directly. However, the British Orthoptic Society, through its annual subscription charge, provides its members with professional and medical negligence insurance and public and product liability insurance.

Rule 2 Relationships with patients

Registered orthoptists shall at all times recognise, respect and uphold the rights, dignity and autonomy of every patient and the patient's role in the therapeutic process. They shall establish the name under which the patient wishes to be known, and they shall also introduce themselves formally to the patient, informing the patient of their rank and the name under which they wish to be known.

This rule covers a wide range of legal rights, including the Human Rights Act 1999, the Data Protection Act 1998, the Disability Discrimination Act 1985, the Sex Discrimination Act 1998 and the Race Relations Act 1976. It also covers civil rights arising from common and case law. These include the right to have cultural customs respected, the right to privacy, the right to complain and the right to have a complaint dealt with appropriately. Equal opportunities issues and the concept of informed consent are also encompassed. Morally, this rule is encompassed in the Hippocratic Oath.

2.1 Consent

There is a general legal and ethical principle, combined with a clinical function, that valid consent must be obtained prior to the commencement of physical investigation and treatment or provision of personal care for a patient. This reflects the rights of patients to determine what happens to their own bodies and is a fundamental part of good professional health care practice. The orthoptist who does not respect these principles may be liable both for legal action by the patient and action by his or her professional or statutory body. Employing bodies may also be liable for the actions of their staff.

There is no English statute setting out the general principles of consent but case law has established that the mere action of touching a patient without valid consent may constitute the civil or criminal offence of battery. In addition, if the orthoptist fails to obtain proper consent and the patient subsequently suffers harm as a result of treatment, this may be a factor in a claim of negligence against the orthoptist involved. Patients are entitled to complain through the National Health Service (NHS) complaints procedures if the consent process has been managed inadequately.

The main functions of consent:

- Legal function, without which any health care practitioner would commit either a crime (battery) or tort (trespass to the patient). *Wilson v Pringle* [1986] 2 AER 400, *Schloendorff v Society of New York Hospital* 105 NE 92 [NY1914].
- Clinical function, in which the health care practitioner has to secure the patient's trust and co-operation and which involves far more extensive counselling regarding the implications, risks and side-effects of treatment than the laws of trespass and battery require. *Sidaway v Bethlem RHG* [1985] 1 All ER

- Ethical function that relates to patient autonomy and their protection from harm.

The elements of consent:

To be effective, consent has to satisfy three conditions:

- Consent must be freely given.
- Patient consent must be an informed consent, i.e. the patient must have requisite knowledge about the procedure
- The patient must be capable of giving consent

This acts as a legal defence to the tort of battery, and is the basis of the doctrine of informed consent.

2.2 Informed consent

2.2.1 Information

In regard to the information to be given to a patient, the orthoptist should always be sure of the standard of care in informed consent. Here there is a balance to be struck between the benefits of the procedure for the patient and the risks of any potential side effects. Orthoptists owe the patient a duty of care to ensure that the right balance is struck in this regard, as their clinical decisions will directly affect the patient.

The orthoptist (and any other health care practitioner) needs to concentrate on the objective sought by the assessment and/or treatment rather than the precise clinical or surgical procedures to be adopted. In most cases of selective treatment, where there is no question of balancing the advantages of beneficial outcome against adverse consequences materialising from a risk inherent even in careful treatment, it will be sufficient to provide a simple, non-technical explanation.

The amount of information given to patients in accordance with accepted medical practice is encompassed in the case of *Sidaway v Board of Governors of Bethlem Royal Hospital* [1985] 1 AER 118. Here, the court held that a medical professional, such as an orthoptist, would not be negligent in obtaining the patient's consent, if he or she only disclosed the risks that would have been mentioned by a responsible body of opinion in that profession. The orthoptist is under a duty to provide the patient with the information necessary to enable the patient to make a balanced judgement in deciding whether to submit to the proposed treatment. More recently, in *Bolitho Pearce v City and Hackney Health Authority* [1997], the court stated that it would depart from the professional practice approach if it saw fit, the ultimate legal test being what the court itself considers a reasonable amount of information to give to the patient.

The orthoptist should allow and encourage the patient to ask questions but, as in *Blyth v Bloomsbury Area Heath Authority* [1987], there is no obligation to disclose all information. When a question is asked, it is sufficient if the information given is that which would be given by a responsible body of medical practitioners.

2.2.2 Competence

Seeking consent may sometimes be difficult because of a patient's disabilities or special circumstances. These may already have prevented the patient from being informed about treatment and may also make it difficult for the patient to communicate a decision. Failure to support those with disabilities could be an offence under the Disability Discrimination Act 1995 and may prevent valid consent from being gained. Advice and support for communicating with patients can be obtained from the appropriate professional agency.

In general, a patient would be considered to have the capacity to give or withhold consent, if capable of:

- Comprehending and retaining treatment information.
- Believing such information.
- Weighing such information in the balance and making a choice.

Patients deserve to know the truth, to participate in decision-making, to refuse to be used for teaching, and to be given full care even when their choice may differ from the orthoptist. The orthoptist should assess patients carefully and each patient should be judged on his or her own merits before an attempt is made to gain consent.

All information relating to informed consent emphasises the following:

- A patient's informed consent must be obtained before carrying out any form of examination or treatment.
- Information must be given to the patient as clearly as possible to avoid ambiguity. Treatment options must be discussed with the patient and include information about significant benefits, risks and side effects. Alternative approaches that could be offered by the orthoptist or other professionals should also be discussed with the patient. This provides the patient with a choice of treatments, where appropriate, and a full explanation of what the orthoptist proposes.
- The orthoptist must ensure that the patient has the opportunity to ask questions and is encouraged to do so.
- Patients must also be informed of their right to decline treatment at any stage with the knowledge that it will not prejudice their future care.
- Patients should have reasonable time and privacy to reach their decisions.
- Consent or the refusal of treatment must be documented in the patient's notes, together with the reason for the refusal.

2.2.3 Obtaining consent

Consequently, consent may be implied by the patient adopting a position for examination - for example, tilting the head back for the instillation of drops – or it may be expressed either by word of mouth or in writing. With most orthoptic interventions, consent by implication or word of mouth is sufficient. It is good practice to document in the patient's notes that consent has been obtained.

The use of tick boxes is not acceptable, and whereas a signature on a consent form does not itself prove that consent is valid, the purpose of the form is to record the patient's decision and also, increasingly, that discussions have taken place. The Medical Defence Union describes the main purpose of the consent form as being 'to provide evidence that the patient gave consent to the procedure in question and that it was obtained with due care and formality'. When written consent is required and forms are used, some indication of the information given, the options offered and how consent was obtained should be included to ensure that the form has legal credibility. Individual Trusts and employers may already have policies that must be followed for particular interventions. The Department of Health produces forms of consent for:

- Patient agreement to investigation or treatment.
- Parental agreement to investigation or treatment for a child or young person.
- Patient/parental agreement to investigation or treatment (procedures where consciousness is not impaired).
- Form for adults who are unable to consent to investigation or treatment.

2.2.4 Consent in children

Children of 16 years of age can consent as if they were of full age, but the Family Law Reform Act 1969 specifically preserves the common law powers of parental consent. In common law, parents may consent on behalf of their children until the age of 18 years. This is on the basis that the consent must be in the best interests of the child.

The House of Lords ruled in the case of *W v W* [1972] Appeal Cases 24, that a parent can give legally effective consent on behalf of a minor for any clinical procedure to which a 'reasonable parent' would consent. In the case of *Gillick v West Norfolk and Wisbech Area Health Authority* [1985] 3 AER 402, the court held that a fifteen year old girl could consent to contraceptive treatment, as she was sufficiently mature to understand the implications of her decision. This has been referred to since that case as the 'Gillick Competent' test. However, since then the courts appear to have retreated somewhat from this position, and in the case of *In Re R* [1991] 4 AER 177 it was held that while the wishes of the minor are relevant, the courts may defer to the view of the parent/guardian.

2.2.5 Refusal of treatment

A competent person over the age of 16 years, or one deemed to be Gillick Competent, is entitled to refuse treatment, even if this treatment is life-saving and even if the reasons for withholding consent are considered irrational, unknown or non-existent. It is illegal to force an investigation or treatment on patients who resist, or who are unable to resist but have made their wishes clear by words or gesture prior to becoming incompetent. Patients may withdraw consent during treatment. If patients do not know that they have these rights, they should be informed. In the event of refusal, the

orthoptist should seek a change of mind by persuasion, but under no circumstances should coercion or deceit be part of the decision making process.

2.2.6 Summary of consent issues

- The mere presence of a patient does not legally imply consent to treatment, but only to attending for the appointment.
- A contractual relationship between a patient and the orthoptist, such as payment for treatment, does not imply consent.
- Informed consent demands that the patient understands all the advantages and disadvantages of the proposed investigation and treatment regime.
- It may be practical to present a written explanation before the first contact, explaining what the patient may expect at assessment or treatment, and then test understanding again or provide further information prior to assessment and treatment.
- If patients are not offered as much information as they reasonably need to make their decision, and in a form they understand, their consent may not be valid.
- At all stages of assessment and treatment, it is essential that the orthoptist is satisfied that valid consent has been obtained, including situations where global consent has been given for other disciplines besides orthoptics to be included in an integrated care pathway.
- Consent may be implied- for example, by the patient self-positioning for assessment – or expressed by word of mouth or in writing.
- The orthoptist should record in the clinical notes when consent, either implied or expressed, is received.
- Some NHS Trusts may have their own policies on the management of consent for examination and treatment which detail specific types of treatment, including orthoptics, which require the use of written consent forms.
- For procedures with a higher risk - for example, the tensilon test for the diagnosis of some cases of myasthenia gravis - written consent must be obtained. However, it is preferable to use diagnostic tests that are less invasive and harmful.
- Unlawful touching, that is, without the consent of the patient, comes within the scope of the criminal offence of ‘assault and battery’ and the possible civil action of ‘trespass to the person’. Unlawful touching could include holding the patient’s head during an assessment.

2.2.7 Treatment without consent

There may be occasions when an orthoptic patient or a potential orthoptic patient may not be able to consent to treatment and where treatment without consent is permissible:

- An unconscious patient is deemed to have consented to all interventions, but any decision made prior to the patient becoming unconscious should be taken into consideration. This might include a ‘do not resuscitate’ order or an ‘advanced directive’.

- Patient incompetence.
- The Mental Health Act 1983 does not cover orthoptic therapy and consent is still required for orthoptic interventions.
- Panic, indecisiveness, irrationality and mental illness do not themselves amount to incompetence. However, if medically diagnosed mental impairment or illness renders the patient incapable of understanding or retaining information so that he or she is unable to make an informed decision and assess risk, this may constitute an incapacity to consent. This situation would need to be re-assessed on a regular basis.
- Refusal of treatment and subsequent action must be documented, and any decisions discussed with other health care professionals within the team. Relatives cannot give consent for adult patients unless they have been given specific powers by the court. However, their opinion should be considered and respected.

2.2.8 Additional issues affecting the informed consent process

Consent for research

The approach to consent in research subjects is encompassed in the Declaration of Helsinki 1964, amended 1983.

Patients who may be potential research subjects must make an informed decision on whether to enrol or continue to participate in any study. Subjects should be fully informed about the purpose of the research, its procedures, potential risks, potential benefits and alternatives, particularly if assessments or treatments may not be funded or be available other than through the trial. There must be no evidence of coercion and it might be considered worthwhile to enrol a third party to gain consent. An assurance should be given that refusal to participate will in no way alter the health care being received. Subjects should be given the opportunity to ask questions and also be informed of their right to decline to participate in orthoptic research at any stage without prejudicing their future care. Information must be communicated in a readily understood language and be provided in writing as well as in spoken form. Omission of consent is only permissible where totally non-invasive procedures are proposed, such as epidemiological studies. Further information regarding consent for research can be obtained from the NHS Research Governance document entitled 'Research Governance Framework for Health and Social Care'.

2.3 Touching patients

Any need to handle or make physical contact with a patient must be carefully explained to him or her and permission obtained to ensure that the patient is prepared. Clinical practice may be open to misunderstanding and misinterpretation resulting in the orthoptist being open to allegations of assault and, consequently, consent must be sought from patients prior to the commencement of any assessment and before any physical contact is made.

Patients may have valid reasons (religious or cultural) for not wishing to be touched which may not constitute an overall refusal of treatment, and the orthoptist must respect the patient's wishes.

2.4 Record keeping

One of the rights every patient expects is that their medical records are full, clear and held securely. The duty of an orthoptist, as part of the scope of practice and to comply with the patient's rights, is to ensure that a full orthoptic record is maintained.

The prime purpose of records is to facilitate the care, treatment and support of a patient. It is essential to provide and maintain a written record of the professional intervention, advice given and outcome of decisions, and entries must be dated and signed and the status of the orthoptist recorded. Accurate, legible, factual, contemporaneous and attributed records and reports of orthoptic interventions must be kept in order to provide information for professional colleagues and for legal purposes. Subjective opinion should be identified as such and should be clinical and relevant.

Provision must be made for the secure and confidential storage of records, and disposal of records should be in accordance with Trust procedures.

2.5 Reluctance to treat a particular patient

It is important, if the orthoptist has either conscientious or moral objections to treating a patient, that these should be clearly recognised and discussed with an experienced colleague. Discussion should also take place if the orthoptist objects to treating a patient on the grounds of unacceptable behaviour of the patient towards the orthoptist. However, if the reason for not wishing to treat a patient is because of the patient's gender, religion, race, sexual orientation or associated medical condition, it is unlikely that any change of orthoptist would be tolerated or allowed (on the basis of the Hippocratic Oath).

Orthoptists may, from time to time, be required to care for people whose views or behaviour they might find personally unacceptable. When patients express views or behave in ways that are offensive or harmful to others, orthoptists are entitled to take reasonable steps to protect both themselves and others, but must ensure a professional approach and behaviour at all times. The orthoptist should make the patient aware when his or her behaviour has become unacceptable or potentially harmful to the orthoptist, to other staff or to other patients. If a patient appears dangerous or unstable, assessment and treatment may be withheld but advice should be sought from an experienced colleague.

In the private sector, where the contract is directly between the orthoptist and the patient, the orthoptist may refuse to treat a patient. The referring medical practitioner must be informed and an explanation given to the patient as and when appropriate.

2.6 Patients and their refusal of care

The incidence of violent and aggressive behaviour by patients against NHS staff has risen in recent years. It is totally unacceptable for any orthoptist to be physically and verbally abused, harassed or threatened by any patients, their relatives or other members of the public. An example of such behaviour may include the refusal by a patient to be treated by an orthoptist from a particular ethnic or racial background.

Employers have a legal obligation under the Health and Safety at Work Act to ensure safety and well being of their staff and should have policies in place to deal with any incidents that may arise.

Patients have the right to consent to treatment and care and to expect the persons delivering care to be competent to do so. They do not have the right to select or reject the person who intends to deliver the care on the grounds of prejudice. The concept of the patient's rights comes with a responsibility as patients to refrain from aggression and prejudice towards staff as outlined in 'Your commitment to the NHS' in 'Your guide to the NHS'.

A member of staff who experiences such behaviour must record the incident in the relevant reporting book and bring it to the attention of his or her manager, who will discuss possible courses of action with the member of staff involved and whether he or she wishes to continue treating the patient. The patient will be warned that such behaviour is not accepted or tolerated and that treatment may be withdrawn if the behaviour continues.

2.7 Interpreters

It is necessary for some patients whose first language is not English, or who are unable to speak English, to be accompanied by a family member who acts as an interpreter between the patient and the orthoptist. It is not appropriate to use children to undertake this role, as interpretation of medical terminology may be difficult and incorrect information may be relayed to the patient.

Every attempt should be made to select, through appropriate channels, a suitable interpreter with the skills and experience to provide an effective interpretation service. It is advisable to record the name of the interpreter in the patient's notes. Alternatively, it may be advisable to use a translator rather than an interpreter to further limit potential misunderstanding and misinterpretation of information.

2.8 Inappropriate relationships with patients

The relationship between the orthoptist and patient is based on mutual respect and trust. If the orthoptist exploits this relationship, whether it be within or outside the treatment environment or in a sexual, physical, emotional, financial or social manner, this is acting in contravention of professional practice. Indulging in relationships may impair the orthoptist's professional judgement and objectivity and/or may give rise to advantageous or disadvantageous treatment of the patient.

2.9 The legal framework

Patients may also seek to exploit this relationship, and the orthoptist should be aware of any signs of this happening and take steps to restore the professional relationship or withdraw from the situation. It may be a criminal offence for the orthoptist to have sexual relations with a patient. It is an offence if the patient is under 16 years and is incapable of giving consent, or of full age without consent. It is also an offence under the Mental Health Act 1983.

However, if the patient is a former patient, the relationship falls outside the treatment arena and if the patient returns for further treatment, another orthoptist must undertake the treatment.

A registered orthoptist is expected to work within the law of the land of the country in which he or she works. If the orthoptist practices beyond his or her professional scope and limitations and in such a way that causes damage to a patient, a patient may have cause to claim under the civil law of negligence. Negligence is a breach of duty of care that results in damage. In order to win a case of negligence, a patient is required to show causation, i.e. that the damage or injury suffered was due to a negligent act or omission on the part of the clinician.

An error of judgement does not necessarily constitute a negligent act, even if damage is caused. If an accident or incident does occur, a full record must be written as soon as possible after the incident, be completely and appropriately signed and be stored safely with the patient's records.

There is evidence of increasing litigation by patients. Provided that orthoptists work safely and effectively and maintain full records, they will not be subjected to a claim of negligence. The importance of having maintained complete and accurate records and a detailed account of any incident cannot be over-emphasised should the court require the information at a later date.

Rule 3 Confidentiality

Registered orthoptists shall ensure confidentiality and security of information acquired in a professional capacity and shall promote the dignity, privacy and safety of all patients. A duty of confidence arises when the patient shares information with the orthoptist.

Confidentiality is an ethical tradition of health care and is encompassed within the Hippocratic Oath. The Data Protection Act 1998 forms the legal framework for this and has been reinforced by the Human Rights Act 1998. This incorporates the European Convention of Human Rights into the law of England and Wales, Article 8 of which Convention protects personal privacy and patient confidentiality. All information given to an orthoptist by a patient, particularly that which is stored in the patient's medical records, must be treated in the strictest confidence. All personnel within the NHS who are involved with patients in the delivery of an orthoptic service should be made aware of, and respect and adhere to, this confidentiality clause (duty of confidentiality).

Legally, confidential information has been defined by the Courts in the case of *Thomas Marshall v Guinle* [1979] 1 Chancery 227, as follows:

- Information, the release of which the person who is the subject of the information, believes would be of advantage to others.
- The owner of the information must believe the information is confidential and secret.
- The owner's belief must be reasonable in the circumstances.
- The use of the information must be judged in the light of usage and practice in the relevant profession.

This would obviously be applicable to a patient's clinical records held by an orthoptist.

Confidential information is protected legally by Action for Breach of Confidence, as set out in the case of *Stephens v Avery* [1988] 1 Chancery 449. To be subject to the legal protection of this action, the information must satisfy the following criteria:

- That it is of the necessary character of confidence.
- That it has been imparted in circumstances implying an obligation.
- That it has been used in an unauthorised manner to the detriment of the party communicating it.

This again would apply to patient records held by an orthoptist.

3.1 Confidentiality and use of information

The issue of seeking consent for the use of information is equally as important as consent for assessment and treatment, and the principles of competence apply.

3.1.1 Use of identifiable clinical information

The written consent of patients must be obtained before using identifiable clinical information such as photographs and videos, whether it is for teaching purposes or publication. Videotaped records can be edited and anonymity maintained by digitalising identifying features.

3.1.2 Use of information for the purposes of audit and research

All information that a patient gives an orthoptist in the course of audit and research must be treated in the strictest confidence. The patient must sign a consent form for any information obtained which might identify that individual patient.

3.1.3 Multi-professional team

Valuable and necessary information is exchanged at meetings of multi-professional teams – for example, those working within a paediatric assessment team or stroke rehabilitation team - and within the ophthalmic team. Patients expect an exchange of information in these circumstances, as the team has the patient's best interest at the heart of the debate. However, it is imperative to ensure that all health care practitioners are aware that confidential information is being exchanged and they must respect this. Only relevant factual information that is appropriate for the patient's well being should be divulged. This exchange of information is an acceptable breach of confidentiality.

3.2 Protection of patient information

Patient health information must be protected through a number of mechanisms:

- Recognising that confidentiality is an obligation for all staff, external contractors and volunteers, and that breach of confidence, inappropriate use of health records or abuse of computer systems may lead to disciplinary measures.
- Recording patient information accurately and consistently so that the correct decisions are made regarding a patient's treatment and that delays and possible errors are avoided.
- Keeping patient information private by not gossiping about cases and taking care when discussing cases in public places.
- Keeping patient information physically and electronically secure.
- Sharing information with appropriate carers by following relevant information sharing protocols setting out the standards and procedures that should apply when sharing confidential patient information with other organizations and agencies. In addition, any enquirers should be identified, and staff should check that callers, whether by telephone or in person, are who they say they are. Official identification should be sought; in the case of a telephone call, a return call can provide a check of identification.

3.3 Requests for information

It is acceptable to release orthoptic information to other health care professionals involved in the patient's care. However, if information needs to be released to other sources, the patient is required to sign a consent form. This is not necessary should the orthoptist need to release information under a statutory authority, or is so directed by a competent legal authority whereby a solicitor is representing the patient and acting with consent, or where it is necessary to protect the welfare of the patient or to prevent harm, or if it is justified in the public's best interest.

By the patient

Patients are sometimes unaware of their diagnosis (for example, a chronic degenerative neurological condition such as multiple sclerosis), may be uncertain why they have been referred to an orthoptist and may then request a diagnosis. Under no circumstances should the orthoptist provide a diagnosis; the health care professional who has overall responsibility for the patient is the only person who should notify the patient of his or her diagnosis.

Access to records by patients must be granted in accordance with the current statutory provision.

By the employer, official sources (DSS, legal profession)

Before disclosing any information, written consent must be obtained from the patient.

By other competent authorities

The nature of the authority should be verified (for example, a private health insurance company with whom the patient has a contract) and the patient's permission sought prior to the disclosure of information.

By the Coroner's Court

The coroner has the power to investigate sudden, suspicious or unexplained deaths. Information should be disclosed to the coroner so that it can be determined whether or not an inquest should be held.

By a Court of Law

Orthoptists cannot claim privilege as witnesses. They may appeal to the judge but, if directed to answer a question, they must answer. Otherwise the orthoptist will be found to be in contempt of court. A subpoena to either attend court or produce documents must be obeyed.

3.4 The law governing access to medical records

Ownership:

The ownership of medical records is the first basis on which access to medical records is governed.

As regards private patients, ownership is subject to the contract between the clinic and the medical professional such as the orthoptist. If there is no contract involved, then the records are owned by the clinic itself. If there is a contract, the record status depends upon the relationship between the orthoptist and the patient. Usually, though, the ownership is vested in the clinic itself.

In the case of public patients, medical records held by a hospital are the property of the NHS while those held by the general practitioner belong to the Strategic Health Authority (SHA).

Common law principles

In the Canadian case of *McInerney v Mcdonald* [1992] 2 MLR 267, it was held that a patient owns his or her clinical records. According to the court, information held on such records is highly private and personal, going to the patient's personal integrity and autonomy.

However, the English courts have held that the opposite applies, i.e. the medical professional, such as an orthoptist, owns the records and hence governs access to the file. The court in this case felt that while the information comes from the patient, the diagnosis is the property of the orthoptist. Consequently, the fact that the information comes originally from the patient is irrelevant. The opinion of the orthoptist belongs to the orthoptist and consequently he or she governs access to the records.

Legislation:

Data Protection Act 1984 and 1998

'Data subjects' (patients) have the right to be told by a 'registered data user' (an orthoptist) whether there is personal information held on computer. If a copy is requested, it has to be supplied. The application has to be accompanied by a fee and the time limit for a response to such requests is forty days. If information regarding another patient would be disclosed in complying with a request, then the request should not be complied with unless that patient consents.

Data Protection (Subject Access Modification) (Health) Order 1987

This provides for 'modified access' to clinical records. In other words, access may be denied if it is likely to cause serious physical or mental harm to the patient or any other patient who may be readily identifiable. This is to be decided upon by an administrator, although consultation with the Head Orthoptist is required. The patient may challenge the validity of the data and have errors corrected. Compensation may be payable if damage or distress is caused by misleading, incorrect or inaccurate information.

Access to Personal Files Act 1987

Orthoptists may be requested to complete reports for social service departments. These will become part of the patient's 'personal file' and will consequently be subject to the Access to Personal Files (Social Services) Regulations 1989. If access is sought, then the provisions of the Access to Health Records apply. Social Services staff are obliged to consult with the orthoptist regarding exemptions from disclosure based on medical reasons as well as the correction of inaccuracies on the file.

Access to Medical Reports Act 1988

The patient has right of access to medical reports provided for employment or insurance purposes, in order to ensure accuracy and avoid serious errors that may prejudice the patient's interests. If an orthoptist is asked for such a report, the patient must give consent, and the report must consequently be held for six months after it has been sent out by the orthoptist. The patient is permitted access to the report during this period, but the patient must make the necessary viewing arrangements with the orthoptist.

The patient is permitted to submit a written request to have the report amended if he or she feels that it is incorrect or misleading. The request may be refused by the orthoptist but the patient's comments must be attached to the report. If, however, the orthoptist agrees to the amending of the report, the insurance company or employer is not permitted to know about it. While access to the report may be denied on medical or mental health grounds, the patient is entitled under the legislation to apply to the court if he or she feels that the orthoptist has not complied with the Act's requirements.

Access to Health Records Act 1990

A patient has the right to see and/or have copies of any records created after 1 November 1991. Records made prior to this date may only be released in order to assist in understanding any records made after that date. An application has to be made, in writing, within twenty-one days – or forty days if the records were made more than forty days prior to the application for access. The patient or patient's agent, court appointees, or the executor or administrator of a deceased patient may make an application. Access may be denied on medical or mental health grounds, or if there is any possibility of a breach of confidentiality in respect of another patient. Any inaccurate or misleading information may be corrected at the request of the patient and, although the orthoptist may refuse the request, a note of it must be inserted into the medical record. A copy of the note of refusal has to be supplied to the applicant patient, who may also apply to the court for access to the record if he or she feels that the orthoptist has not complied with the requirements of the Act.

3.5 Breach of confidentiality and disclosure of information

- Disclosure of information may be justified on the grounds that it is in the public's best interest that some circumstances, such as investigation of a crime, might override the health care practitioner's duty to maintain the patient's confidence. (*W v Edgell* [1990], *Duncan v The Medical Practitioners Disciplinary Committee* [1986], *Tarasoff v Regents of University of California* [1976])
- Information may also be disclosed for the purpose of a medical research project approved by a recognised ethical committee.
- Information may be disclosed to comply with statutory requirements such as notification of an infectious disease as ordered by the Public Health Act 1984.

3.6 Security of information

Patients' clinical records, whether in manual or electronic form, should be stored in a secure manner at all times. Orthoptists should avoid leaving portable computers, medical notes and files in easily accessible areas and unattended in cars. Ideally, all files and portable equipment should be kept under lock and key when not actually being used. In the case of community orthoptists, arrangements should be made to ensure that records are held securely in a lockable cabinet or, when transported, in the locked car boot – and they must not be kept in the car overnight. Procedures for safeguarding the information effectively should be agreed locally.

Trusts should have protocols, administered by Caldicott Guardians and in conjunction with the Data Protection Act 1998, for the holding of electronic records. Terminals should not be left unattended when logged-in; shared log-ins must be avoided and passwords not revealed. In addition, the screen displaying a patient's information should always be cleared before another patient is seen.

If sensitive and confidential information is communicated via email, it must be transmitted via a secure server or be encrypted. Similarly, if information is faxed, the person requiring the information must be available to receive it directly, a requirement achievable by making contact immediately before transmission of the information.

3.7 Difficulties in confidentiality

The following examples illustrate and give guidance on how to deal with difficult situations that may arise in respect of confidentiality:

- If a patient is proposing to undertake an activity, which because of their clinical condition could be harmful to themselves and others – such as driving – the orthoptist must try to persuade the patient not to undertake this activity by identifying the possible consequences of doing so.
- An orthoptist should only breach confidentiality in good faith and where the patient's vision is likely to make him or her a danger to themselves or others if they drive. The orthoptist is advised to discuss this breach with a medico-legal adviser, and the patient's GP should also be informed. The orthoptist also has a moral duty to inform the medical authorities at the DVLA.
- If suspicious of a case of non-accidental injury, the orthoptist should refer the matter to a nominated officer dealing with these types of incidences.

Rule 4 Relationships with professional staff and carers

Registered orthoptists shall communicate and cooperate collaboratively with professional staff and other carers in the interests of the patient and with the patient's consent, and shall avoid inappropriate criticism of their colleagues.

Orthoptists shall work in such a way as to promote good health in a clinically effective manner with due consideration of cost. This may involve working in different locations and within multi-disciplinary teams.

4.1 Obligations

Orthoptists have an obligation to work professionally by:

- Participating effectively in multi-professional approaches to health care delivery, liaising with ophthalmologists, optometrists and other professionals.
- Assisting other health care professionals in professional practice by, for example, educating health visitors and nurses about vision screening or educating specialist junior medical staff.
- Assisting in the clinical education of orthoptic undergraduates in line with the government's educational governance policies.
- Acknowledging cross-professional boundaries and employing appropriate referral procedures.
- Initiating and maintaining effective interactions with relevant external agencies including other health care professionals.
- Deploying and managing support staff effectively and efficiently.

4.2 Responsibilities

Orthoptists have a responsibility to ensure that interventions made on the basis of their assessment are necessary and appropriate.

Orthoptics is an autonomous profession and the responsibility for assessment and subsequent treatment remains with the individual orthoptist. Written or verbal referrals may be accepted from medical practitioners.

These responsibilities include those:

- To the patient: to ensure that expectations are not raised that cannot be fulfilled, and not to waste time or treat patients for whom the treatment would not be beneficial or has ceased to be beneficial.
- To themselves: by treating a patient who does not require such treatment, an orthoptist could be in contravention of a statement of professional conduct. It is morally wrong and unacceptable to give treatment when it is not required or when referral to another specialist is deemed more appropriate.

- To the employer: irrespective of whether the orthoptist is employed through a Trust or self-employed and working privately, it is ethically wrong to waste time and money by treating patients unnecessarily.

4.3 Requests for unnecessary and dubious treatment

Situations may arise where the referring practitioner may request treatment but the orthoptist feels that it is not justified in terms of benefit to the patient. In such instances, the orthoptist should raise his or her concerns with the referring practitioner and explain the reasons why, or approach a senior colleague.

4.4 Whistle blowing

With increasing accountability, it is essential that all registered orthoptists are aware of the mechanisms that are available to them regarding ‘whistle blowing’ following the introduction of the Public Interest Disclosure Act 1998.

If an orthoptist has reasonable grounds to believe that the behaviour or professional performance of a colleague of whatever discipline is below the level of professional competence required, these grounds should be forwarded to the nominated officer within the Trust responsible for these issues. Likewise, if there are any other concerns such as staffing levels that the orthoptists feels may be compromising or endangering patients, these must also be reported.

Members employed in the NHS should be aware of the nominated officer within the Trust and should feel comfortable about seeking advice should untoward circumstances present. All staff are protected in these circumstances.

It is unacceptable and inappropriate to use ‘whistle blowing’ to resolve personal, partnership or business disputes. In these circumstances, any areas of concern must be raised with the individual colleague.

Rule 5 Duty to report

Registered orthoptists have a duty to report, to an appropriate authority, any circumstances that may put patients, others, or themselves at risk.

This encompasses the Health and Safety at Work Act 1974 and the Public Interests Disclosure Act 1998.

Orthoptists may work in a variety of environments, such as community clinics and schools, paediatric assessment centres and within hospitals. All environments can present risks for the patient, and orthoptists are expected to be aware of health and safety rules and procedures and to ensure that they, their patients and colleagues comply with these.

In the NHS any risks identified that cannot be dealt with by the orthoptist or the line manager must be reported to the appropriate authority, normally the Trust's Risk Manager and usually in writing.

More recently, medical practitioners have been suspended by the General Medical Council for not reporting the known and acknowledged incompetence of practice of a colleague. The Secretary of State for Health supports the action of colleagues reporting incompetent behaviour to the appropriate authority. Orthoptists are therefore reminded and advised to maintain their own competency as required, assist colleagues to maintain their own standards and levels of practice, and to report incompetent practice to the appropriate authority in the best interests of the patient. The use of the professional mentoring scheme and continuing professional development should assist in ensuring that standards are maintained.

'Whistle blowing' has received much coverage in the NHS in the last few years. Orthoptists are reminded that if they have a concern regarding staffing levels, rationing of care or other Trust activities, which they believe have the potential to endanger or discriminate patients in any way, they must go through the Trust's procedures before airing their views in public.

Rule 6 Personal and professional standards

Registered orthoptists shall adhere at all times to personal and professional standards that reflect credit on the profession. They must not engage in any criminal, unprofessional or any other unlawful activity or behaviour. In addition, behaviour, approach and dress should not cause offence to the patient or carer.

6.1 Disciplinary procedure by the Health Professions Council

Any adverse findings by the Health Professions Council will render an orthoptist liable to disciplinary proceedings. Matters brought before the Health Professions Council may be raised as a breach of the British Orthoptic Society's Rules of Professional Conduct and Code of Ethics.

6.2 Disciplinary proceedings by an employer

Disciplinary proceedings by an employer concluding with dismissal from employment may also lead to a charge of professional misconduct. This applies even if the orthoptist has not been involved in court proceedings. A disciplinary proceeding resulting in a reprimand or warning will not normally give rise to disciplinary action by the Society or the Health Professions Council.

6.3 Personal conduct derogatory to the reputation of the profession

Personal conduct that does not result in a conviction or disciplinary action by the employer, may be deemed sufficiently serious to warrant disciplinary action by the Society if such conduct is judged to be derogatory to the reputation of the profession. Misuse of alcohol, drugs and other toxic substances may be dealt with as a health matter in the first instance and then progress to a disciplinary hearing. Orthoptists should not undertake any professional activities after consuming alcohol, drugs or other toxic substances.

6.4 Conviction by a court

It is important that all circumstances that have resulted in a conviction are considered, as the conviction might be evidence that the orthoptists' continued practice may imply a risk to the patient and public. Not all convictions will result in action being taken.

Rule 7 Advertising

Registered orthoptists shall ensure that advertising in respect of their professional activities is accurate and professionally restrained.

An orthoptist can advertise but such advertising must be accurate, legal, honest and truthful and professionally restrained. It is important to maintain a professional patient and health care practitioner relationship and it is therefore considered unethical to appeal in person to potential patients. Advertising on a website, through leaflets or advertisements in free newspapers that can be accessed directly by patients is therefore unacceptable.

Advertisements, whether written or audio-visual, should not be false, fraudulent, misleading, deceptive, self-laudatory, unfair or sensational. The use of qualifications and titles should also meet these criteria. Professional signs should be dignified and, again, professionally restrained. Explicit claims of superiority should not be made in respect of personal skills, equipment or facilities. Orthoptists should not accept commission from third parties for recommending the purchase of goods or services related to their professional status when practising. Failure to observe these requirements could result in disciplinary action being taken by the Health Professions Council.

Appendices

Appendix 1: Acts

Data Protection Act 1998

This Act makes new provision for the regulation of the processing of information that identifies individuals (personal data). It was introduced to comply with the EU Data Protection Directive and was implemented on 1 March 2000.

The Act is complicated and its full impact will not be known until test cases have come before the courts; the NHS Executive is still in discussion as to how it will affect the NHS and practices. However, it is important to comply with the Act because not to do so is a criminal act.

Processing includes:

- The holding, obtaining, recording, using and sharing of information, and the Act applies to all forms of media including paper and images.

Personal data is defined as:

- Data relating to a living individual who can be identified from
 - a) those data, or
 - b) those data and other information which is in the possession of, or likely to be in the possession of, the data controller

and includes any expression of opinion about the individual and any indications of the intentions of the data controller or any other person in respect of the individual.

Although there are some similarities between this Act and the Data Protection Act 1984, there are some important differences:

- The Act now covers certain types of manual records (including all health records) as well as electronic records. There are transitional arrangements concerning manual records until 2007.
- The definition of 'processing' is wider than the 1984 Act and includes the concepts of obtaining, storing and disclosing of data. Most actions, including storage, will be included within this definition.
- Although both the 1994 and 1998 Acts include eight Data Protection Principles, the nature of the principles differs between the two Acts.
- The Access of Health Records Act 1990 permitted access to manual health records made after the Act came into force (1 November 1991). The Data Protection Act 1998 permits access to all manual health records whenever made, subject to specified exemptions.

Schedule 1: Principles of the Act

Personal data:

- Must be processed fairly and lawfully and, in particular, shall not be processed unless at least one of the conditions in *Schedule 2* is met and, in the case of sensitive data, at least one of the conditions in *Schedule 3* is also met.

- Shall be processed for one or more specified and lawful purposes, and shall not be processed in any manner incompatible with that purpose or purposes.
- Shall be adequate, relevant and not excessive in relation to the purpose or purposes for which they are processed.
- Shall be accurate and where necessary up to date.
- Shall be kept no longer than necessary.
- Shall be processed in accordance with the rights of data subjects under this Act.
- Shall be protected under appropriate security.
- Shall not be transferred to a country or territory outside the European Economic Area unless an adequate level of protection is ensured.

Schedule 2: Conditions relevant for the purpose of the first principle (processing of any personal data)

The data subject has given consent.

- The processing is necessary for the performance of a contract with the data subject.
- The processing must comply with any legal obligation other than a contract.
- The processing is necessary to protect the vital interest of the data subject, i.e. life or death situation.
- The processing is necessary to carry out public functions and the administration of justice.
- The processing is necessary to pursue the legitimate interest of the controller unless prejudicial to data subject interests.

Schedule 3: Conditions relevant for the purpose of the first principle (processing of sensitive personal data)

The data subject has given explicit consent to the processing of the personal data.

- The processing is necessary to comply with legal rights or/ obligations as an employer.
- The processing is necessary to protect the vital interests of the data subject or another.
- The information has been made public deliberately by the data subject.
- The processing is necessary to obtain legal advice and for exercising legal rights in connection with legal proceedings.
- The processing is necessary to carry out public functions.
- The process is necessary for medical purposes undertaken by a health professional or someone with equivalent duty of confidentiality.
- The processing is necessary equal opportunities monitoring.

Further information can be obtained from the Department of Health's publication Data Protection Act 1998; Protection and Use of Patient Information (HSC 2000/009).

Disability Discrimination Act 1995

Section 21 of the Disability Discrimination Act 1995 requires all service providers, including providers of health and social care services, whether within the NHS or outside the NHS to:

- Take reasonable steps to change practices, policies or procedures that make it impossible or unreasonably difficult for disabled people to access a service.
- Provide auxiliary aids or services which would make it easier for or enable disabled people to use a service.
- Overcome physical features that make it impossible or unreasonably difficult for disabled people to use a service by providing a service by reasonable alternative means.

The Health Service Circular HSC 1999/156 issued by the NHS Executive in July 1999 sets out the action that all NHS employers are expected to take to implement Section 21. The report entitled 'Working in Partnership to implement Section 21 of the Disability Discrimination Act across the Health Service' provides a framework of good practice and includes a detailed checklist and audit tool to help service providers ensure that they have covered every area of their service.

Health Act 1999

Schedule 3 relates to the regulation of health care and associated professions. It highlights an Order which makes provision, in relation to any profession, for any of the following matters (amongst others):

- The establishment and continuance of a regulatory body.
- Keeping a register of members admitted to practice.
- Education and training before and after admission to practice.
- Standards of conduct and performance.
- Discipline and fitness to practice.
- Investigation and enforcement by or on behalf of the regulatory body.
- Appeals.
- Default powers exercisable by a person other than the regulatory body.

Health and Safety at Work Act 1974

General duties on employers and others

These duties are outlined in sections where the obligations are qualified by the phrases 'so far as is reasonably practicable' and 'best practicable means'.

Section 2: Employers' duties to employees

Section 3: Employers' duties to non-employees

Section 7 and 8: Employees' duties

Section 2: Employers' duties to employees

- To ensure that plant and systems of work are safe and without risk to health.
- To ensure that the use, handling, storage and transportation of articles and substances are safe and without risk to health.
- To provide suitable and sufficient information, instruction, supervision and training.
- To maintain the premises in a safe condition, without risk to health and with suitable means of access and egress.
- To maintain the workplace in a safe condition, without risks to health and with adequate facilities and arrangements for their welfare.

Section 3: Employers' duties to non-employees

The employer has a duty to conduct his work in such a manner that it is without risk to the health and safety of non-employees such as:

- Patients
- Clients
- Visitors
- Contractors

Section 7 and 8: Employees' duties

- To take reasonable care of themselves and others who may be affected by their acts and omissions.
- To co-operate with the employer and to meet any health and safety requirements placed on them.
- Not to intentionally or recklessly interfere with or misuse anything provided by the employer in the interests of health, safety and welfare.

Since the introduction of the Management of Health and Safety at Work Regulations 1992:*Regulation 11:*

- The employer must provide the employees with adequate health and safety training at the time of recruitment.

Regulation 12:

- The employee must inform the employer of any shortcomings or risks to health and safety in their workplace of which they are unaware.

Human Rights Act (1998)

The Human Rights Act 1998 came into force in the UK on 2 October 2000, giving further rights enshrined in the European Convention on Human Rights. In future, it is expected that courts will take into account the case law of the European Court of Human Rights in Strasbourg as well as English case law. Potentially, this legislation could have serious implications for people's rights but the full extent of its impact on English medical law will not be known

until test cases have come before the courts. The following articles within the Human Rights Act are likely to be relevant:

Article 2: Protection of the right to life.

Article 3: Prohibition of torture, inhuman and degrading treatment or punishment.

Article 5: The right to liberty and security.

Article 8: The right to respect for private and family life, home and correspondence.

It underscores the duty to protect the privacy of individuals and preserve the confidentiality of their health records. It is assumed that compliance within the Data Protection Act 1998 and the common law of confidentiality should satisfy the Human Rights requirements.

Article 9: The right to freedom of thought, conscience and religion, including the right to manifest religion or belief in worship, teaching, practice and observance.

Article 12: The right to marry and found a family.

Article 14: The prohibition of discrimination in the enjoyment of Convention rights.

Article 14: The right to enjoy all other Convention rights without discrimination on grounds such as sex, race, colour, language, religion, political or other opinion, natural or social origin, association with a national minority, property, birth or other status.

Race Relations Act 1976 as amended by Race Relations (Amendment) Act 2000

The Race Relations Act 1976 (Part 1) makes it unlawful to discriminate against anyone on the grounds of race, colour, nationality (including citizenship) or ethnic or national origin. The Race Relations (Northern Ireland) Order also includes religious belief or political opinion. The Acts apply to education, facilities and services, housing, jobs and training and the provision of goods.

Discrimination may be:

- *Direct racial discrimination:* whereby someone is treated less favourably on racial grounds than others in similar circumstances. It includes racist abuse and harassment.
- *Indirect racial discrimination:* whereby someone from a particular racial group is less likely to comply with a requirement or condition and the requirement cannot be justified other than on racial grounds.
- *Victimisation:* whereby someone is treated less favourably because he or she has complained about racial discrimination or has supported someone else who has.

The Act (Part II) covers all employers, irrespective of the number of employees, and gives protection to most employees including the self-employed and those working for someone else on a contract. It also applies to anyone providing goods, facilities or services to the public which must not be refused or provided on less favourable terms than those offered to other people of other racial groups.

The Race Relations (Amendment) Act 2000 extends the Race Relations Act 1976 to prohibit discrimination in all functions of public authorities. Anyone whose work involves functions of a public nature must not discriminate on racial grounds whilst carrying out those functions. This means that all functions of public authorities, including the NHS, will be subject to the Race Relations Act 1976. The Act will also apply to any private or voluntary agencies carrying out any public functions, such as providing services for NHS patients. All such activities must be free from racial discrimination.

Public authorities such as the NHS must also have due regard to the need to eliminate unlawful discrimination and promote equality of opportunity and good race relations in carrying out their functions. They will be expected to consider the implications for racial equality of everything they do such as opening or closing a hospital. The Commission for Racial Equality will be issuing Codes of Practice to provide practical guidance to public authorities on how to fulfil their general and specific duties.

Sex Discrimination Act 1975 amended 1986

The Sex Discrimination Act (SDA) and Sex Discrimination (Northern Ireland) Order make it unlawful to discriminate on the grounds of sex. Discrimination is not allowed in employment, education, advertising or when providing housing, goods, services and facilities. It is unlawful to discriminate in employment or advertisements for jobs because someone is married or has children. The Equal Pay Act (EPA) (1975) (amended 1984) states that women must be paid the same as men when they are performing equal work.

Discrimination is defined as:

- *Direct discrimination:* whereby someone is treated unfairly because of sex.
- *Indirect discrimination:* whereby unjustifiable conditions are set that appear to apply to everyone but in fact discriminate against one sex.
- *Victimisation:* whereby someone is treated unfairly for trying to exercise rights under the SDA, Order or EPA.

Employers must not discriminate against a person because of their sex or gender reassignment or because they are married. This applies to recruitment, treatment during employment, chances for promotion and transfer, training, dismissal or redundancy.

The Children Act 1989

This Act, which came into force in England and Wales in 1991, brings together and consolidates both public and private law relating to children and young persons. The Act revoked large areas of pre-existing law and set up a new framework for the protection and care of children with the establishment of clear principles to guide decision making in relation to their care. The overriding principle is that the child's welfare shall be the court's paramount consideration.

The principles that the law should consider are as follows:

- The welfare of the child must be the paramount consideration in court proceedings.
- Wherever possible, the child should be brought up and cared for in his/her own family.
- Courts should ensure that delay is avoided so that minimum disruption is caused to a child's life, and may only make an Order if to do so is better than making no Order at all.
- Children should always be consulted (subject to age and understanding) and should be kept informed about what happens to them, and should participate when decisions are made about their future.
- Parents continue to have parental responsibility for their children even when their children are no longer living with them.
- Parents with children in need should be helped to bring up their children themselves. This help should be provided as a service to the child and his/her family and should:
 - be provided in partnerships with parents
 - meet each child's identified needs
 - be appropriate to the child's race, culture, religion and language
 - draw upon effective partnership between the local authority and other agencies including voluntary agencies.

The involvement of the child in the decision-making process is also a major principle. Whilst the considerations set out below apply to specific decisions to be made under The Children Act 1989 (Section 1(3)), there are good reasons for orthoptists to follow these same considerations in the care of the child, namely:

- The ascertainable wishes and feelings of the child concerned, considered in relation to his or her age and understanding.
- His or her physical, emotional and educational needs.
- The likely effect on him or her of any change in his circumstances.
- His or her age, background and any characteristics that the court considers relevant.
- Any harm which he or she has suffered or is at risk of suffering
- How capable each of his or her parents, and any other person in relation to whom the court considers the question to be relevant, is of meeting his or her needs
- The range of powers available to the court under this Act in the proceedings in question.

Appendix 2: Glossary of Terms

Assault: A threat of unlawful contact.

Autonomy: Autonomy or self-rule or self-determination based on the principle of respect for persons.

Battery: A crime is committed through the intentional bringing about of a harmful and offensive contact with the patient. It represents the importance of the individual patient's right to determine what should or should not be done to their body and this includes any bodily touching of their body without their consent. 'Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without the patient's consent commits an assault'. *Schloendorff v Society of New York Hospital* 105 NE92 [NY, 1914]).

Beneficence: Principle of beneficence implies the duty to do good. In the negative sense, this is interpreted as preventing harm (non-maleficence) and in the positive sense, it means producing benefits of some kind.

Bolam Test: The test applied by the courts on the standard of care expected of a professional in cases of alleged negligence, i.e.: that of 'the ordinary skilled man exercising and professing to have that special skill'. *Bolam v Friern Hospital Management Committee* [1957].

Consent (express): The patient clearly states that he or she is willing to undergo proposed treatment. This can take the form of a verbal discussion in which the health care practitioner explains the benefits to be expected and the risks that may be incurred. It may also be in the form of writing such as on a consent form.

Consent (implied): This is given many times in health care practice by the sheer action of the patient. It extends to the realms of investigation and treatment.

Duty of care: A duty of care exists where one person can reasonably foresee that his or her actions and omissions could cause reasonably foreseeable harm to another person. A duty of care will always exist between the health care professional and the patient, but it might not always be easy to identify to which people a duty exists.

Gillick competent: Children under 16 years of age who have sufficient understanding and intelligence to be capable of making up their own minds can give valid consent to treatment which signifies a child has the maturity and competence to make a decision in the specific circumstances arising. *Gillick v West Norfolk and Wisbech AHA* [1985].

Negligence: This is the most common tort and involves the bringing of actions in situations where the plaintiff/claimant alleges that there has been personal injury or death, or damage or loss of property caused by another. Compensation is sought for the loss that has occurred. To succeed in the action of negligence, the plaintiff/claimant has to prove the following elements:

- That the defendant owed a duty of care to the person harmed
- That the defendant was in breach of their duty
- That the breach of duty caused reasonably foreseeable harm to the plaintiff/claimant.

Subpoena: A writ ordering a person to attend a Court of Law.

Tort: A civil wrong excluding breach of contract. It covers negligence, trespass to the person, goods or land, nuisance, breach of statutory duty and defamation.

Vicarious liability: The liability of an employer for the wrongful acts of an employee committed whilst in the course of employment.

Whistle blowing: This refers to a person, usually an employee, who draws attention to concerns that have health and safety implications.

Appendix 3: The Hippocratic Oath/ Declaration of Geneva (amended by the World Medical Association 1994)

Whatever, in connection with my professional practice or act in connection with it, I see or hear on 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.

I solemnly pledge myself to consecrate my life to the services of humanity

I will give to my teachers the respect and gratitude which is their due

I will practise my profession with conscience and dignity

The health of those in my care will be my first consideration

I will respect the secrets that are confided in me, even after the patient has died

I will maintain by all the means in my power, the honour and the noble traditions of my profession

My colleagues will be my brothers and sisters

I will not permit considerations of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation or social standing to intervene between my duty and my patient

I will maintain the utmost respect for human life from its beginning, even under threat, and I will not use my specialist knowledge contrary to the laws of humanity.

Appendix 4: The Declaration of Helsinki (1964) amended 1983

In any research on human beings, each potential subject may be adequately informed of the aims, methods, anticipated benefits and potential hazards of the study and the discomforts it may entail. He should also be informed that he is at liberty to abstain from participation in the study and that he is free to withdraw his consent at any time. The doctor should then obtain the subject's freely given consent preferably in writing. The distinction needs to be that therapeutic research consisting of an activity that also has a therapeutic intention towards the subject of research and non-therapeutic research which does not have a therapeutic intention.

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