THE ETHICAL OPHTHALMOLOGIST
Commercial Relationships ● Compensation ● Advertising

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(Material adapted from the *The Ethical Ophthalmologist: A Primer,* a text by the Ethics Committee of the American Academy of Ophthalmology.)

Summary: This course covers ethical issues and concerns and their impact on every day decision-making in ophthalmology. The case study approach, with questions and discussion, provides an opportunity to recognize and analyze ethical dilemmas. These learning activities will also heighten awareness of ethical and moral principles in certain aspects of contemporary medical practice such as research and new technology, delegated services, commercial relationships, compensation, and advertising.

Audience: Ophthalmologists, eye care professionals, and ethicists.

Objectives: After completing The Ethical Ophthalmologist: Course II, you should be able to explain the ethical approach you would take in dealing with commercial relationship, compensation, and advertising issues.

Accreditation: The American Academy of Ophthalmology is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians.

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CME: CME credit is available to all users of this educational activity.

Financial Disclosure: The authors acknowledge no financial interest in the subject matter of this course.

Editor's Note: This text is for educational purposes. It is intended to promote discussion and understanding of the ethical issues facing ophthalmologists. This text does not interpret, modify, amend, or supplement the Code of Ethics of the American Academy of Ophthalmology or any of the Advisory Opinions.

All names used in the case studies in this text are fictitious, and have no intended relationship to any persons involved in any past or present ethics matter considered by the Academy's Ethics Committee. Any similarities in the names chosen in the case studies to those of actual ophthalmologists or other persons are entirely coincidental.

Finally, although this project was undertaken with the full support and encouragement of the Academy's Board of Trustees, and was completed with the invaluable assistance of the Academy staff and resources, the text itself is the sole product of, and responsibility of, the individual authors and editors.

INTRODUCTION
Ethical principles and behavior are an integral part of the practice of medicine. For this reason, the ability to recognize and act on ethical issues is an essential qualification of the competent ophthalmologist.

Imagine, for example, that several patients have contacted you recently for a second opinion on the urgent need for cataract extraction. Each surgery was recommended by one particular ophthalmologist in your community. In each case, you find that new glasses improve the patient's vision to a level entirely satisfactory to the patient. What do you tell the patients? Do

you have a larger responsibility to protect other patients from unnecessary surgery? What obligation do you owe the other ophthalmologist?

Another example: a 3-year-old boy with developmental delay and cerebral palsy is brought to you for evaluation of esotropia and moderate hyperopia by concerned parents. The parents tell you that the child was recently examined by another eyecare professional who told them it was impossible to determine whether the child could see, and that the correction of strabismus with glasses and surgery was not advised because "it would really be just for cosmetic purposes and wouldn't last." What do you tell the parents?

Neither of these two examples constitutes a life and death matter, and neither would be considered an ethical crisis. Yet, such situations raise a host of issues that test the ophthalmologist's knowledge, understanding, sensitivity, compassion, and moral judgment - in brief, his or her ethical awareness and behavior. Similar predicaments, some more mundane, some more dramatic, are part of the practice of medicine. Yet practical guidance in how to deal with these events has largely escaped attention in most of the books that fill our professional libraries. There is no *Duke Elder* or *Duane's* textbook to provide instruction. We may recognize the ethical competence of our physician role models and we can learn from them, but a specific presentation of ethical issues that permeate the practice of ophthalmology could prove a useful adjunct. Such a guide might serve to increase our moral awareness and competence in managing the obligations of our profession. These courses attempt to fill that need.

It should be clear, this is not a "cookbook" or "how-to" handbook for ethical conduct. It is only a guide. You will note that there are questions related to the various case studies presented. These are offered to illustrate the fact that, in many instances, no single response is the only correct course of action. Conflicting ethical concerns may be present; alternatives exist, and the physician must bear the choices based on the ethical principles that pertain to the conditions of the situation described. Hopefully, this activity can aid the teaching and learning process in which physicians become better healers: healers of their patients, their communities, and themselves.

Go to next page for course curriculum.

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COMMERCIAL RELATIONSHIPS
Until recently, the complexity of new commercial relationships was not of great concern to most physicians. Traditional codes of ethics forbade alliances that would result in financial gain from other than professional services. In days past, morally responsible physicians would shun relationships that had even the appearance of a commercial enterprise.

For economic, social, political and other reasons, attitudes have changed drastically from the traditional hands-off posture of the past. Commercial relationships of all varieties now abound, involving physicians and affecting their patients. New associations with optometrists, opticians, health maintenance organizations, insurance companies, hospitals, technology companies, and the pharmaceutical industry have perhaps forever changed the doctor-patient relationship.

Case #1
Dr. Baker is new in her community. She is invited to lunch by an optician who offers to refer patients in return for referral of those patients back for dispensing. Dr. Baker does not dispense in her office. She attends the lunch and agrees to accept patients with the understanding that they will be directed back to their referring optician. Dr. Baker knows she cannot insist that a patient return to this particular optician, but since the patients will have come from him in the first place, she assumes they will probably return on their own accord.

Dr. Baker believes that patients who do not need a change in glasses should be told so, and should neither be encouraged to get new ones nor discouraged from doing so. She

realizes that people sometimes tire of old glasses even though they are working well. The optician schedules another lunch with Dr. Baker. He explains that patients have been coming back to him reporting that Dr. Baker said they did not need new glasses. Dr. Baker tells the optician that is correct. The optician asks Dr. Baker if she could perhaps word her advice differently. Perhaps she could tell the patient to return to the optician to look at some of the newer styles that are now available. Dr. Baker really does not want to become a marketing agent for the optician; on the other hand, she really appreciates the referral of new patients. How should Dr. Baker respond to the optician's request?

Case #2
Dr. Ellis is considering a contract with a managed care organization which would capitate her for certain ophthalmic services. (Capitation means fixed reimbursement for the provision of all necessary care to a person for a specified period of time.) She is uncertain whether she would be happy with this arrangement. Reimbursement for some services might be reasonable, but she is financially at risk in the management of certain potentially complex cases. Depending on the case mix, she could lose money. Is it fair to herself to sign such a contract? Is it fair to the patients? Will she be tempted to do less than she believes appropriate, because to do more would be at her own expense?

Case #3
Dr. Ebson has received a list from Medicare of his maximum allowable charges, based on the AMA Resource-Based Relative Value Study (RBRVS). In looking at some surgical procedures, he notes that reimbursements are so low that he would lose money if he took time away from his office duties to perform them. He also notes that some surgical procedures which require extensive follow-up are so poorly paid that he would be financially ahead if he did the surgery at no charge. In this instance, he would not fall under the 90-day global fee restriction on additional billings associated with the surgery, and thus could bill for each office visit the patient required. Given the extensive follow-up usually required with these surgeries, he would come out financially ahead. He is tempted to utilize this ploy, but questions its propriety. He wonders if it is ethical to maximize payment in this way.

Thought Questions
A. Should an ophthalmologist refer patients back to a referring optician for glasses when little or no change in correction is necessary?

B. What are the ethical considerations when a physician signs a capitated payment contract with a managed health care organization?

C. How should a physician respond to the new and different payments he or she will receive under Medicare's Resource-Based Relative Value Scale?

Discussion
Each of the three physicians in the case studies faces a relatively new situation for ophthalmologists. Their problems are interrelated in that they all deal with the business aspects of practicing ophthalmology. Thinking about and dealing with these issues are consuming progressively more of the physician's time and energy. Of greater concern is the change that this new business perspective has produced in the ethical relationship between doctor and patient.

The ethical questions we must ask ourselves are these: As physicians and ophthalmologists, are we satisfied with the present commercial climate of health care delivery? Are we willing to adapt, look to our own welfare, and to assume that proficient performance of our technical duties alone will serve the best interests of our patients? If we are not satisfied, can the present trend be reversed? What can be done? What can we do?

Some proposals and answers to these questions have been provided in a thoughtful and provocative article by Arnold S. Relman, M.D., former editor-in-chief of the *New England Journal of Medicine.* An editorial comment preceding the article observes, "[Dr. Relman] fears that his profession has lost its ethical way. Doctors, he argues, are not, and should not

become businessmen, and yet financial and technological pressures are forcing more and more of them to act like businessmen, with deleterious consequences for patients and for society as a whole." (Relman, A.S., What Market Values Are Doing to Medicine, *The Atlantic Monthly*, March 1992, p 99106)

In the article itself, Dr. Relman reviews the historic ethical position of physicians. From its beginnings, medicine "has steadfastly held that physicians' responsibility to their patients takes precedence over their own economic interest." The Hippocratic oath and the International Code of the World Medical Organization emphasize this principal. In its 1957 *Principles of Medical Ethics*, the American Medical Association stated that "the principal objective of the medical profession is to render service to humanity..." In the practice of medicine, a physician should limit the source of his professional income to medical services actually rendered by him, or under his supervision, to his patients. Because of its pledge to comply with these admonitions, the medical profession has enjoyed a privileged position in society, and society expects ethical behavior in return. Why don't medical practice and commerce mix? What distinguishes the two? Dr. Relman says, "Patients depend on their physicians to be altruistic and committed in advising them on their healthcare needs and providing necessary medical services . . . ." In contrast, in a commercial market, multiple providers of goods and services try to induce customers to buy." How did professionalism and medicine give way to market forces? Dr. Relman explains that over the past few decades, an increase in the number of physicians and hospitals has led to an intense competition for paying patients. "Professionalism among self-employed private practitioners thrives when there is more than enough to do. When there isn't, competition for patients and worry about income tend to undermine professional values and influence professional judgment."

Specialization and technological advances have increased the price of services and increased the financial rewards of medicine. Since insurance largely insulates the health care consumer from the costs, there is little incentive to control burgeoning costs. Investor-owned health care businesses are now common, and their number is growing because of the opportunities for profit. Nearly two-thirds of the health maintenance organizations, insuring about 35,000,000 persons, are investor-owned. Dr. Relman calls this "corporatization of health care."

Dr. Relman adds, "This corporatization of health care, coupled with increasingly hostile and cost-conscious policies by private insurance companies and government, has had a powerful and pervasive effect on the attitudes of health care providers – including those in the not-for-profit sector". Corporatization has made traditionally altruistic and benevolent community hospitals and their physicians take a hard look at the bottom line. Hospital marketing programs to secure more paying patients are the norm. Physicians, too, are resorting to advertising and other marketing techniques to attract more business. Physicians are investing in healthcare facilities to which they can refer their patients. Thus, they earn income for their professional fees and from revenue generated when patients use their facilities. Dr. Relman points out that "this is a clear violation of the traditional ethical rule against earning professional income by referring patients to others or by investing in goods and services recommended to patients." Physicians in private practice and in academic institutions are subject to many business arrangements with drug companies and medical device manufacturers that compromise their professional independence.

In addition to these commercial relations that tempt physicians, the courts have played an important role in fostering a market-driven profession. In 1975, the US supreme court decided that antitrust law applies to the professions. Hence, the door was opened for advertising by -physicians; to prevent it would be anticompetitive. The Code of Ethics of the AMA was changed to comply with the ruling of the Court and the Federal Trade Commission. An added statement declared that competition is "not only ethical but is encouraged."

Government policies of the past 12 years have strongly supported competition, believing that this would help control costs. Dr. Relman observes, "In business, success is measured in terms of increasing sales volume and revenues – the last thing we want to see in the health

care system.” At last, recognizing this inevitable result of competition, government is now taking other steps to control costs. Dr. Relman summarizes his reflections in these sentences: “Medical care, I suggest, is in many ways uniquely unsuited to private enterprise. It is an essential service, requiring the involvement of the community and the commitment of healthcare professionals. It flourishes best in the private sector, but it needs public support, and it cannot meet its responsibilities to society if it is dominated by business interests.”

This change in the climate for practicing medicine has been called "the corporatization of health care." What is the solution to this health care problem? Changes are needed, but changes in a different direction. Dr. Relman favors changes that put physicians in a most favorable position to act as prudent advocates for their patients rather than as entrepreneurial vendors of services. Regardless of what structural changes in the healthcare system are ultimately adopted, physicians hold the key.

COMPENSATION
Compensation is defined in this context as payment or remuneration for services provided to patients. Such compensation may take many forms: direct payment from patients, reimbursement from private third party payers, or government insurance agencies, and others. Many factors may affect levels of compensation. These include the mode of practice, such as fee-for-service or health maintenance organizations, government regulations, and the ethical issues surrounding care for those patients without private insurance who are unable to pay.

Case #4
An ophthalmologist is caring for a 20-year-old diabetic student with severe proliferative retinopathy. The patient is covered by her parents' insurance company because she is a college student. Panretinal photocoagulation is recommended to both eyes. Treatment involves 900 - 1200 spots of argon laser, which can be applied either at one sitting or multiple sittings. It is elected to perform the laser in 200 spots per visit. Payment is received from the insurance company for each visit. Four treatments are completed on each eye.

At this point the patient graduates from college and gets married. She no longer has insurance, but she qualifies for Medicaid. When she returns to the doctor's office for her next treatment, she tells the clerk of her new status. She is informed that the doctor does not accept Medicaid patients and that she must find another doctor.

Thought Questions
A. Should the delivery of medical care depend on the patient's ability to pay or the mode of payment?

B. What are the reasonable fees for service?

Discussion
The ophthalmologist in this case study may have failed to consider several important aspects of this patient's care. The first is the social, emotional, and financial needs of the patient prior to treatment. A thorough patient history and pretreatment assessment might have revealed the patient's pending plans to graduate from college and might have called into question her future health care coverage under her parents' insurance plan. A different schedule of treatment appropriate to the patient's condition might have been implemented so that the final treatments would have been performed before her graduation.

The physician in this case chose a treatment option that made the complete pattern of laser take a total of at least four visits for each eye. By charging for a laser on each visit, the reimbursement from the insurance company is more substantial than if more spots were placed each visit. There are certainly considerations of patient employment and pain tolerance that influence the number of spots placed per visit, but by making the number of visits a strong financial consideration for the physician, there is a conflict of interest in deciding treatment options. This might be avoided by charging one fee for procedure, then letting the patient's needs dictate how that procedure is to be accomplished.

Additionally, the ophthalmologist has abrogated a responsibility to the patient by refusing to continue to treat when her insurance coverage and, consequently, her method of payment changed. Because the ophthalmologist has already begun treatment of the patient, the obligation exists to provide for continuity of care. Failing to do so could be viewed as abandoning the patient. The ophthalmologist should either agree to continue to treat the patient or, with the patient's approval, refer her to another, equally qualified ophthalmologist who would assume full responsibility for the care of the patient and who would accept Medicaid payment.

Case #5
Dr. Adams has concluded that the various reimbursement strategies in current medical insurance plans interfere with his relationship with his patients. He decides that he will participate in no relationships with third-party payers. He structures his office on a straight fee-for-service basis with charges set at levels he thinks are fair. Patients are informed of this policy on the first contact with the office and are told payment is due at the time of service. Each patient who is seen in the physician's office agrees to this policy, and both the patient and Dr. Adams are happy with the arrangement.

Jonathan is a two-day-old boy who has been diagnosed with bilateral congenital cataracts. Dr. Adams is the only physician in the area who has the skill and equipment to perform the cataract surgery Jonathan needs. Jonathan's family wants the surgery, but on discussion with Dr. Adams' staff, they realize that they are unable to afford to pay Dr. Adams' full fee in a lump sum. They offer to pay installments on the amount over a period of several months. Dr. Adams' new receptionist feels that this violates the policy of the office and recommends that the family save up the money and return when they can afford to pay in full for the operation. The family agrees. Neither the new receptionist nor the family realizes that a delay in the surgery will mean a significant loss of visual potential for Jonathan.

Thought Questions
A. Is the physician/patient relationship simply a business relationship and subject to the same rules as an ordinary business?

B. Does a physician have a right to be compensated for services at a level the physician feels is appropriate?

C. What obligation does a physician have to protect the welfare of an individual patient, and of society in general?

Discussion
The current atmosphere of reimbursement for medical care certainly makes Dr. Adams' choice of a compensation policy understandable and attractive. Physicians see fees, and even the direction of medical care, determined by non-physicians in the offices of insurance companies or by the government. Financial reward often goes to the physician who can provide services at the lowest cost. This often involves a decrease in services to the patients. The most ethical of physicians may be near despair.

This case illustrates the physician's ethical responsibility to transcend modes of payment. The patient, Jonathan, is in a totally dependent position and is not competent to understand options of treatment or payment. As surrogates for the patient, Jonathan's parents were not informed that his need for cataract surgery is emergent to maximize his visual function. The office staff used Dr. Adams' policy as a first screening mode in rejecting Jonathan as a patient. Jonathan needs an agent to guide him and his family through the medical system. Dr. Adams has the knowledge and the skill to help him, either directly or by finding another qualified physician to provide appropriate care. The second consideration is Dr. Adams' obligation to society. The training of physicians requires some use of public resources. Physicians often train in medical schools and public hospitals and with loans financially supported by members of society. It is not unreasonable to believe that physicians have a responsibility to share their skills in part to meet the needs of society.

Finally, physicians have a right to be compensated for their work. However, when physicians use compensation as the deciding factor in patient care, they are no more compassionate than the insurance companies. The physician-patient relationship is no longer a trusting relationship between one with skills and one with needs, but becomes only a business relationship. The patient and doctor become adversaries rather than the physician acting as the patient's advocate. Medicine is de-professionalized, and neither the physician nor the patient is well served.

ADVERTISING
The threshold principle in medical advertising is that communications to the public must be accurate. This principle does not hold ophthalmologists or other professionals to an unrealistic standard, that they must never be wrong. The principle simply requires that communications to the public not be false, deceptive, or misleading.

Case #6
Dr. Bennett is a well-respected cataract surgeon, with an expanding practice in a small Southwestern city. On several occasions he has offered his services to a charitable organization that transports him and other eye professionals to less-developed countries to perform eye surgery for periods of a week. Dr. Bennett has not published any papers in major journals, but has lectured at CME seminars on three separate occasions.

Generally, he lectures on his success with a particular brand of intraocular lens in cataract surgery, noting his low rate of postoperative complications. Although his practice is largely local, he occasionally operates on visitors from abroad, particularly Latin Americans.

In order to stimulate his practice still further, Dr. Bennett places advertisements in local newspapers each Sunday. The ad states in part: "If you need cataract surgery, don't you want a top surgeon? Call Dr. Bennett, a surgeon who is famous around the United States and in many other countries. Dr. Bennett has pioneered certain advances in cataract surgery and participated in developments in the field. He has lectured on his accomplishments to medical groups across the country. You will be in experienced hands." Another ophthalmologist in the same city has inquired whether this advertisement contravenes the Academy's Code of Ethics.

Thought Questions
A. What fundamental ethical principle is violated in this case?

B. Why should or shouldn't physicians advertise?

C. What elements of advertising present problems for medical advertising?

Discussion
This advertisement is misleading in several respects. Merely traveling extensively, presenting addresses at professional meetings, or treating patients from abroad does not mean that a physician has an international reputation. To so indicate is to use the inherent imprecision of the concept of fame to mislead patients. There can be little question that such claims are employed in order to give patients the impression that the surgeon meets some objective, high level of competence, skill, or recognition, which probably does not apply to this advertiser. The same is true of Dr. Bennett's claim to be a "top surgeon."

Saying that one has "pioneered certain advances in cataract surgery" is also deceptive in this case. Such a phrase clearly connotes a major breakthrough, not a minor alteration or refinement of conventional procedures. Simply being one of many investigators for one type of IOL, or using a slightly refined surgical procedure, does not justify a hyperbolic term such as "pioneered." Since all surgery requires some degree of innovation, a surgeon cannot meaningfully claim to be an originator or developer of a technique or product simply because he or she has modified in some minor way what previously existed.

Use of the phrase "participated in developments in the field" suffers from a different flaw.

Read literally, it means virtually nothing; its only purpose is to suggest an accomplishment where none exists. Obviously, every surgeon, by performing surgery and maintaining patient records "participates in" the accumulation of information on which advances in surgical techniques are based — just as every human being contributes to the "evolution of mankind toward wisdom and progress." To advertise such phrases is misleading unless the ophthalmologist has personally contributed specific advances that have been adopted by colleagues. This does not appear to be true of Dr. Bennett. Thus, Dr. Bennett appears to have acted unethically by engaging in advertising that is designed to, and might well, deceive potential patients.

Analysis of Principles

Standards of ethical medical practice established prior to the twentieth century prohibited advertising. In 1847, a Code of Medical Ethics stated:

It is derogatory to the dignity of the profession, to resort to public advertisements or private cards or handbills, inviting the attention of individuals affected with particular diseases, publicly offering advice and medicine to the poor gratis, or promising radical cures; or to publish cases and operations in the daily prints or suffer such publications to be made; to invite laymen to be present at operations to boast of cures or remedies, to educe certificates of skill and success, or to perform any similar act. These are the ordinary practices of empirics, and are highly reprehensible in a regular physician.

Advertising was not considered a highly respected undertaking for professionals as recently as 1949, as illustrated by the World Medical Association Declaration of Geneva:

A doctor must not allow himself to be influenced merely by motives of profit. The following practices are deemed unethical: . . . any self-advertisement except such as expressly authorized by the National Code of Medical Ethics. A doctor is advised to use great caution in publishing discoveries. The same applies to methods of treatment whose value is not recognized by the profession.

By 1957 strict opposition to advertising by medical professionals appeared to be weakening. In that year, the American Medical Association merely noted that physicians should not solicit patients. No direct reference to advertising was made. The premise for advertising by medical professionals was provided by the Sherman Anti- Trust Act of 1890. This law led the way to allowing and even encouraging professionals to advertise. The Sherman Anti-Trust Act was designed to promote competition by discouraging monopolistic practices. In 1975, the notion of competition finally became applicable to organized medicine when the Federal Trade Commission successfully sued the American Medical Association over the issue of restricting advertising through its Code of Ethics. In 1997, it became unlawful for physicians to restrict advertising. New ethical concerns have arisen from the advertising by managed care organizations and by corporations forming relationships with physicians, such as those being formed to set up photorefractive surgery networks. Managed care organizations may incorporate physicians' services into their advertisements containing claims of superiority that cannot be substantiated or that are deceptive. What is a physician's responsibility in this situation? Similar conflicts may occur when physicians allow corporations to present information to the public about refractive surgery that they feel may be unethical, but where physicians have no rights to prevent such information from reaching the public. In general, physicians will need to be increasingly concerned with the ethics of those organizations that they become associated with, be they hospitals, physician groups, managed care organizations, or other corporate entities.

RELATED RESOURCES

For additional information related to subject matter addressed in this course, we suggest investigating the following:

- American Academy of Ophthalmology, Code of Ethics
- American Medical Association, Principles of Medical Ethics
- World Medical Association, The International Code of Medical Ethics and the Declaration of Geneva
- The Hippocratic Oath

- Advertising Directives

TEST
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Directions: To receive CME credit, please print and complete both pages of the test and course evaluation forms below, and submit them to the Clinical Education Division of the Academy by fax (415.561.8533) or mail (P.O. Box 7424, San Francisco, CA 94123). CME credit is available to all users of this educational activity.

Test Question: In Case #5, it would have been more ethical for the physician to rank the issue of method of payment below the decision on treatment, and actively intervene in the discussions between his office staff and the parents.

Please write a response indicating whether you agree or disagree with the above statement, and include your reasons.

Evaluation: Please indicate your agreement with the following statements about this course.

1. This online ethics course met its stated objectives.

   Strongly Agree 1 2 3 4 5 Strongly Disagree

2. The topic area was comprehensively covered.

   Strongly Agree 1 2 3 4 5 Strongly Disagree

3. The information presented in this course will be useful in my practice.

   Strongly Agree 1 2 3 4 5 Strongly Disagree

4. The option of downloading and printing the course material is important.

   Strongly Agree 1 2 3 4 5 Strongly Disagree

5. CME credit was an important reason for taking this online course.

   Strongly Agree 1 2 3 4 5 Strongly Disagree

6. I would recommend this online course to others.

   Strongly Agree 1 2 3 4 5 Strongly Disagree

Your name (please print):_____

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