AMERICAN ACADEMY™
OF OPHTHALMOLOGY

ADVISORY OPINION OF THE CODE OF ETHICS

Subject: Appropriate Examination and Treatment Procedures

Issues Raised: How is it determined which examination and treatment procedures are considered appropriate and necessary?

Applicable Rules:
Rule 2. Informed Consent
Rule 6. Pretreatment Assessment
Rule 8. Postoperative Care
Rule 9. Medical and Surgical Procedures
Rule 10. Procedures and Materials

Background

This Advisory Opinion is not intended to require or proscribe specific medical practice, to define a standard of care, or to endorse specific practice patterns. It is specifically recognized that the examinations and treatment procedures that may be appropriate will vary depending on many factors, including the patient's condition and history; the skill, experience, and judgment of the physician; other available sources of care; and patient choice. Moreover, in the vast majority of cases, there is substantial room for different judgments as to what procedures in a given case are appropriate and warranted by cost-benefit considerations. This Advisory Opinion is intended to provide general guidance only. It includes some examples of the types of care that deviate so obviously from the range of appropriate professional judgments that they clearly present unethical conduct.

First Inquiry

Facts - Mr. Smith is a 70-year-old man whose ophthalmologist told him that his decreasing vision was due to age-related macular degeneration. When Mr. Smith consulted a second local ophthalmologist, this conclusion was confirmed, and the physician added that there appeared to be microscopic evidence of very early cataracts. Both ophthalmologists advised Mr. Smith that the cataracts were not of sufficient density to be causing the decline in vision he reported.

A month later, Mr. Smith visited his sister in a distant city. Through newspaper and television ads, Mr. Smith learned of Dr. A, an Academy Fellow, and went to see him.

After examining Mr. Smith, Dr. A told him that there was an excellent chance that cataract surgery with an intraocular lens implant would restore his vision, and he did not mention Mr. Smith's macular degeneration. Surgery was scheduled. Dr. A operated on one of Mr. Smith's eyes one day and on the second eye the next day. A few days later, Mr. Smith returned home and received follow-up care from his primary ophthalmologist. Examination revealed no visual improvement at 1 month and 3 months postoperatively. Mr. Smith is angry, and he has inquired whether Dr. A acted ethically.

Resolution - Although theoretically possible, it is highly improbable that Mr. Smith's cataracts progressed substantially in the brief period between the time he was seen by the second local ophthalmologist and the time he visited Dr. A. Therefore, in the absence of some relatively unique circumstances, it appears that Dr. A performed surgery that was unnecessary; it did

not present a reasonable prospect of benefit to the patient and certainly not any sufficient benefit in light of the usual risks and costs of surgery.

Dr. A appears to have violated Rule 6 of the Code of Ethics, which provides that "surgery shall be recommended only after a careful consideration of the patient's physical, social, emotional, and occupational needs." Dr. A appears to have not performed an adequate examination, since he did not mention to the patient the presence of macular degeneration and thus likely did not detect it. There is no indication that he asked Mr. Smith about the results of the examinations performed only 1 month prior, or that he attempted to obtain the examination records from Mr. Smith's local ophthalmologists.

By virtue of his (likely) failing to diagnose macular degeneration and consider it as the most probable cause of Mr. Smith's decreased vision, Dr. A incorrectly informed Mr. Smith that cataract surgery would improve his vision. As a result, he did not accurately convey the expected benefits of surgery and thus did not obtain a valid informed consent, in violation of Rule 2 of the Code of Ethics. The macular degeneration should have been identified by Dr. A and considered in the decision to recommend cataract surgery after the collection of an adequate history, review of previous examination reports, and the performance of a complete eye examination, including a dilated fundoscopic examination.

Finally, it appears that Dr. A may have not provided adequate postoperative care, in violation of Rule 8 of the Code of Ethics. Dr. A did not contact either of the local ophthalmologists before surgery to ensure that one of them would be able to provide postoperative care for the patient. Co-management of postoperative care with a qualified practitioner must be arranged prior to surgery and must be agreed to in advance by the patient and the co-managing practitioner. The patient's welfare and rights are the primary considerations.

Second Inquiry

Facts - Dr. B, a member of the American Academy of Ophthalmology, has a large office staff that assist him in performing various diagnostic procedures. His office instruments include argon and YAG lasers, a specular microscope, A and B scan ultrasonographic units, a fundus camera, and automated visual field instruments.

Dr. B usually follows patients every 6 months and orders fundus photos of his adult patients at all routine eye examinations. He explains that he initially wants to obtain baseline images and then assess for changes in the optic nerve appearance with later photos. Likewise, all adult patients also receive automated visual field evaluations at each semiannual examination. Chronic open-angle glaucoma patients return every month for an intraocular pressure measurement by a technician, but they are not examined during these monthly visits by Dr. B. In addition, Dr. B orders corneal endothelial cell counts for all patients diagnosed with cataracts, regardless of the visual significance of the cataract.

Mrs. Jones, a 35-year-old patient of Dr. B for many years, received a bill for her semiannual examination, which included fundus photos, visual fields, and specular microscopy, and she was surprised by the dollar amount. She has asked the Academy if Dr. B is performing unnecessary tests.

Resolution - Without examining the patient, it is difficult to generalize about what procedures are necessary and what procedures are unnecessary for a given patient at a given moment in time. Therefore, we do not believe that one can say that any given conventional diagnostic procedure is "generally" not useful; one must consider the clinical evaluation of the individual patient and the information that is needed to best serve the interests of that patient. In addition, it is particularly difficult to definitively distinguish between thorough medical practice and defensive medicine or between aggressive treatment and needless service. It also must be recognized that not all practitioners can operate with equal skill, intuition,

confidence, and judgment. Some may require more diagnostic tests than others in order to manage their patients comfortably and competently.

Despite these difficulties, it is still possible to identify certain practices that are excessive or unnecessary. If a diagnostic procedure is performed that is not of substantial value in diagnosing disease, evaluating disease progression, or predicting the future course of a disease, the best interest of the patient is typically not served by performing the test. All diagnostic procedures are associated with a cost that must be borne by the patient, provider, or third-party payor, and in many instances they are also associated with some risk to the patient. In the absence of a reasonable expectation of a benefit provided by performing a procedure, it may be considered unnecessary. Charging fees for services for which there is not some substantial benefit exploits patients and payors. Both of these features make such practices unethical for ophthalmologists.

In this case, Dr. B appears to have acted unethically because he has established a uniform schedule of diagnostic tests without consideration of the particular needs of individual patients or the likelihood that they would benefit from the tests. Fundus photos are not generally necessary or useful if performed at every examination in glaucoma patients. The same is true of visual field examinations during routine visits in the absence of any actual or suspected pathology. The evaluation of corneal endothelial cell counts is not generally regarded as a necessary component of the clinical evaluation of every cataract patient. The failure of Dr. B to perform a medical evaluation of the patients at these visits is an indication that his motives are possibly pecuniary and that the patients are not receiving proper and efficient medical care. Although each of these procedures may be quite justifiable and even necessary in particular cases, it appears to be unethical for Dr. B to apply them in every case regardless of specific need, whether he does so for financial gain or for reasons relating to defensive medicine.

Third Inquiry

Facts - Dr. D, a Fellow of the Academy, is a high-volume cataract surgeon. She performs posterior capsulotomies with the YAG laser within the first year after cataract surgery on almost all patients in whom an intracapsular posterior chamber intraocular lens is placed. She uses 5 to 10 laser bursts in each eye at each session and has the patient return for a repeat session every 2 to 3 months. Dr. D has a busy practice all day Saturday, performing this procedure on patients at 5-minute intervals. Dr. D charges patients for these services on a per-visit basis.

Resolution — Although the ultimate service (posterior capsulotomy) that Dr. D is providing may be necessary, she is providing it in a manner that is inefficient, more costly, and less convenient for the patient. Generally, such laser treatments can be completed in a single session. In addition to the inefficiency of multiple YAG treatments, the fact that Dr. D performs YAG laser treatments on **almost all** of her postoperative cataract patients suggests an excessive use of the procedure, exploiting patients and payors. Since this mode of administering the treatments is not medically justifiable and does not serve the patient's interests, it violates Principle 5 and Rules 9 and 10 of the Code of Ethics.

Fourth Inquiry

Facts - Mrs. Patel, a 78-year-old woman, comes to the office of Dr. G, asking for a general eye exam. She asks specifically if she has glaucoma. Dr. G, a member of the Academy, finds her visual acuity to be 20/40 in each eye, which he believes is due to the presence of early cataracts. The intraocular pressure measures 20 mmHg in each eye. The optic discs appear healthy, without cupping. Dr. G obtains more history and finds that his new patient believes

that her eyes are just fine, that she is being treated for acute leukemia diagnosed 6 months ago, and that she is quite discouraged because she is feeling ill.

Dr. G informs Mrs. Patel that her intraocular pressure is higher than normal and that it is a good thing that she came to see him. He orders optic disc photographs and automated visual field testing, which demonstrates mild generalized depression. He prescribes timolol 0.5% in each eye twice daily and advises her to return to his office in 1 week so that he can evaluate the effect of the timolol. The patient returns 1 week later, at which time Dr. G finds that the intraocular pressure is 18 mm Hg in each eye.

Dr, G orders another automated visual field examination, which again shows mild generalized depression. Mrs. Patel tells him that for the past week she has been feeling worse than usual and has been having a sense of unsteadiness when she stands up. Dr. G tells her that the fact that the intraocular pressure decreased in response to the timolol proves that she has glaucoma, that she is now in much better condition than before, and that she should continue the timolol. He instructs her to return in 3 months for a repeat visual field examination.

Resolution - Dr. G appears to have acted unethically in the care that he has provided to Mrs. Patel. He has ordered unnecessary diagnostic tests and therapy and clearly is not putting the patient's best interests first. Urgent, extensive, and repeated testing for glaucoma in a patient whose intraocular pressure is not excessively high and who has no clinical appearance of glaucomatous optic nerve damage and no risk factors for glaucoma is typically not warranted even if the patient has a complex medical history. Furthermore, treatment for glaucoma in this clinical scenario is without clinical indications. All glaucoma treatment can be associated with side effects, and the topical beta blockers are no exception. Given that the side effects associated with glaucoma treatment in this case appears to far outweigh the potential benefits, the patient was given erroneous information regarding clinical evidence that confirms her disease; in addition, she has developed a known side effect of the chosen treatment and has been harmed. Rather, a frank discussion with the patient concerning her fears, her general medical status, and the goals for future monitoring of her ocular health would have served the patient's needs better. Besides violating Mrs. Patel's autonomy, Dr. G misled her. This inquiry presents a case in which Dr. G has clearly acted unethically by employing patently unnecessary and inappropriate procedures.

Applicable Rules

"Rule 2. Informed Consent. Informed consent is the process of shared decision-making between the ophthalmologist and the patient and must precede the performance of medical or surgical procedure. During the informed consent process, pertinent medical and surgical facts, and recommendations consistent with standard of care in medical/surgical practice must be presented in understandable terms to the patient or patient surrogate. Such information should include the indications, benefits, objectives, risks and possible

complications of the procedure, alternatives to the procedure, and the potential consequences of no treatment. The operating ophthalmologist must personally confirm comprehension of this information with the patient or patient surrogate."

"Rule 6. Pretreatment Assessment. Treatment (including but not limited to surgery) shall be recommended only after a careful consideration of the patient's physical, social, emotional and occupational needs. The ophthalmologist must evaluate and determine the need for treatment for each patient. If the pretreatment evaluation is performed by another health care provider, the ophthalmologist must ensure that the evaluation accurately documents the

ophthalmic findings and the indications for treatment. Recommendation of unnecessary treatment or withholding of necessary treatment is unethical."

"Rule 8. Postoperative Care. The providing of postoperative eye care until the patient has recovered is integral to patient management. The operating ophthalmologist should provide those aspects of postoperative eye care within the unique competence of the ophthalmologist (which do not include those permitted by law to be performed by auxiliaries). Otherwise, the operating ophthalmologist must make arrangements before surgery for referral of the patient to another ophthalmologist, with the patient's approval and that of the other ophthalmologist. The operating ophthalmologist may make different arrangements for the provision of those aspects of postoperative eye care within the unique competence of the ophthalmologist in special circumstances, such as emergencies or when no ophthalmologist is available, so long as the patient's welfare and rights are the primary considerations. Fees should reflect postoperative eye care arrangements with advance disclosure to the patient."

"*Rule 9. Medical and Surgical Procedures*. An ophthalmologist must not misrepresent the service that is performed or the charges made for that service. An ophthalmologist must not inappropriately alter the medical record."

"Rule 10. Procedures and Materials. Ophthalmologists should order and/or utilize only those laboratory and surgical procedures, optical devices or pharmacological agents that are in the best interest of the patient. It is unethical to prescribe or provide unnecessary services and procedures or seek compensation for those services. It is equally unethical to withhold necessary services or procedures."

Other References

"*Principle 1. Ethics in Ophthalmology*. Ethics address conduct, and relate to what behavior is appropriate or inappropriate, as reasonably determined by the entity setting the ethical standards. An issue of ethics in ophthalmology is resolved by determining what best serves the interest(s) of patients."

"*Principle 3. Providing Ophthalmological Services*. Ophthalmological services must be provided with compassion, respect for human dignity, honesty and integrity."

"Principle 6. Fees for Ophthalmological Services. Fees for ophthalmological services must not exploit patients or others who pay for the services."

American Medical Association Code of Medical Ethics Opinions 9.6.6 ("Prescribing and Dispensing Drugs and Devices") and 1.2.3 ("Consultation, Referral and Second Opinions"). Available at: https://www.ama-assn.org/search?search=Code%20of%20Medical%20Ethics%20opinions&sort_by=search_api_relevance&page=1.

American College of Surgeons, Statements on Principles, Code of Professional Conduct, J. ("Unnecessary Operations"). Available at: https://www.facs.org/about-acs/statements/stonprin.

American Academy of Ophthalmology. *Advisory Opinion of the Code of Ethics,* "Determining the Need for Medical or Surgical Intervention." Available at: https://www.aao.org/clinical-education/redmond-ethics-center.

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