



## ADVISORY OPINION OF THE CODE OF ETHICS

Subject:	Ethical Obligations in Managed Health Care
Issues Raised:	What are the ethical dimensions involved in participating in a managed health care delivery system, and what are the ophthalmologist's responsibilities to the patient, to himself or herself, and to society with respect to the Academy's Code of Ethics?
Applicable Rules:	Rule 2. Informed Consent Rule 4. Other Opinions Rule 6. Pretreatment Assessment Rule 8. Postoperative Care Rule 9. Medical and Surgical Procedures Rule 10. Procedures and Materials Rule 11. Commercial Relationships Rule 14. Interrelations Between Ophthalmologists Rule 15. Conflict of Interest Rule 17. Confidentiality

### Background

Managed care is a system of health care delivery that seeks to favorably influence the utilization and cost of services while improving performance by objective standards. The goal is a system that delivers value through access to high-quality and cost-effective health care, with an emphasis on preventive care. Managed care alters the nature of relationships—doctor to patient, doctor to payor, doctor to hospital, and doctor to colleague. At the core of these relationships is the ophthalmologist's understanding of the profession, and, in particular, an increasing awareness of the potential conflicts that can arise between professional and business aspects of the practice of medicine. In this rapidly changing healthcare environment, capitated care models are becoming less common.

The American Academy of Ophthalmology's Code of Ethics does not address specific methods of reimbursement. Its Principles and Rules remain unchanged despite the change in reimbursement systems in a managed care environment. However, ethical dilemmas not previously encountered now face ophthalmologists who are involved in managed care. These dilemmas continue to arise as a result of changes in insurance industry products and reimbursement methods. This Advisory Opinion is designed to address some of these dilemmas but not newer payment models such as Accountable Care Organizations.

The practitioner's freedom to make decisions about patient care, style of practice, and professional relationships with colleagues may be affected in this environment. Those decisions are routinely influenced by third-party payors consistent with participation agreements signed by the practitioners. Individual ophthalmologists may be asked to place new emphasis on cost of treatment against the anticipated benefits of the treatment. Pay-for-performance systems that measure performance based on specific clinical measurements provide incentives for physicians who meet these goals. Such models may incentivize practitioners to avoid treatment of patients who may adversely affect their pay-for-performance metrics. The urgency of addressing the dilemmas raised by changes in health care reimbursement has increased as the insurance industry and government have become more influential in health care reimbursement, access, and quality improvement efforts.

The potentially adverse economic impact under managed care must not compromise the care provided to patients. Above all, professional and ethical responsibilities take precedence over business endeavors. Ophthalmologists must recognize the continuum of health care delivery systems, the perceived value placed on medical care by the public, the tradition of our profession, and the responsibility to make tomorrow's system better for patients. Each of the following inquiries reaffirms that the overriding principle in the ethical practice of medicine is for the ophthalmologist to be the patient's advocate and to act in the patient's best interest.

#### First Inquiry

*Facts* - Dr. D was asked to analyze the patient population he covers for a managed care entity. He carefully computed the costs for cataract surgery and bid for a capitated contract. He projected that a reasonable profit might be realized without cutting corners or changing the group's established practice patterns. His group was subsequently awarded the contract. In the first months of service, he noted an unexpectedly high incidence of cataracts in his group's patient population. When a patient with 20/400 cataracts was led in by a friend, Dr. D asked the patient if she had wanted surgery sooner. "Dr. S said my cataracts weren't ripe yet and that I might be too old to have surgery," she replied. At once, the flaw in Dr. D's projections struck him. Dr. S, the prior contract holder, apparently had discouraged surgery in a large number of his capitated patients, thus keeping his expenses low within the capitated system. The untreated backlog now presents a problem for Dr. D and his group.

*Resolution* - Considering the case of Dr. D, surgical volume ideally should be determined by the visual needs of the patients, should be consistent with disease prevalence in a population, and should not change when payment systems change. However, the economic motivations of an ophthalmologist may influence presentation of the patient's options for cataract management. In a fee-for-service model, an attempt to do more surgery by exaggerating the impact of a visually insignificant lens opacity is a serious ethical violation. Likewise, it is equally unethical to minimize the impact of a visually significant cataract. In both cases, personal gain of the surgeon is placed above serving as an advocate for the patient's best interest (see Principle 5).

Even though Dr. D's group now has more cataract patients than anticipated, this should not influence surgical decisions for any single patient. If the group responded by discouraging appropriate surgery, Dr. S's previous exploitation of his contractual arrangement would only be perpetuated. However, if Dr. D's group performs all the cataract surgeries they believe are indicated, they may be at risk for significant financial losses. The group's options are limited to either increasing efficiency or decreasing costs in ways that do not adversely affect outcomes. It may be appropriate for Dr. D to notify the managed care entity of the dilemma. Notably, he and the group are contractually obligated to provide patients with the care they need. Although it would be difficult, it is also appropriate for Dr. D to approach Dr. S for a frank discussion of Dr. S's patient management. If collegial discussions are unsuccessful, referral to professional entities that review such behavior, including the Academy's Ethics Committee, may be indicated. This inquiry emphasizes further the importance of understanding managed care contracting and careful review of the contract. Performing what is required under a managed care contract must not conflict with the patient's best interests. In such a situation, competent legal review is also recommended.

#### Second Inquiry

*Facts* - Dr. C is scheduled to see a new patient, a 4-year-old child with the diagnosis of Stickler's syndrome. Records have been forwarded to Dr. C, documenting the child's prior care at the local university medical center. Included in the records are copies of correspondence from the child's parents to their pediatrician demanding that care be continued at the university. The family's new HMO refuses the request and designates Dr. C as the new in-network ophthalmic provider.

*Resolution* – Dr. C has an obligation to provide competent care for all of her patients. Dr. C should provide the care only if Dr. C has the appropriate training and skills necessary to treat this patient with Stickler’s syndrome. A frank discussion must be held with the parents to establish a new doctor-patient relationship with clear communication about her expertise. If the child’s parents do not have confidence in Dr. C, then a further opinion is required from either the original ophthalmologist or from another appropriate individual. Throughout the ensuing discussions, Dr. C must always act as the patient’s advocate in communicating with the child’s pediatrician and the HMO decision-makers until a mutually satisfactory solution is achieved. Communication between Dr. C, the child’s first ophthalmologist, and the parents may be critical to facilitate the most appropriate course of action.

Acting as this child’s advocate may adversely affect Dr. C’s financial relationship with the HMO. In a capitated system, Dr. C may be responsible for the cost of this patient’s care by an out-of-network ophthalmologist. The Code of Ethics requires that patient care decisions not be affected by economic interests even as ophthalmologists forge relationships with managed care organizations.

### Third Inquiry

*Facts* – Dr. M is a retina specialist who works for an HMO. He cares for a large population of elderly patients who have macular degeneration. Recently, a new device for treatment of nonexudative macular degeneration has become available and has been approved for research. The treatment involves a short surgery under local anesthesia, which Dr. M feels comfortable performing and which can potentially decrease the risk of vision loss and development of geographic atrophy in this patient population. This HMO does not cover experimental treatments and has advised Dr. M to tell patients that they must either go outside the HMO for this specific treatment at their own cost or receive standard care within the HMO with AREDS vitamin supplementation.

*Resolution* - In this case, the patient’s right (or lack thereof) of access to experimental treatment is at issue. The physician always has an obligation to do what is in the patient’s best interest. At a minimum, such experimental treatment must undergo review. The physician is obliged to maintain competence as newer techniques are developed and to discuss with the patient what is known about such techniques in the process of informed consent. The nonavailability of the procedure within the HMO presents added responsibilities to Dr. M. He might address this issue by providing referrals to ophthalmologists outside the plan who are competent to provide this service (Rule 4) and by lobbying on the patient’s behalf within the HMO’s structure.

Each managed care organization has an obligation to explain fully the extent of coverage, in advance, to potential subscribers. If experimental treatments are not covered, the patient should be made aware of this prior to enrolling in the plan. The HMO should provide clear advance notice of coverage to avoid a confrontational relationship between the patient and the physician in the future. More difficult issues arise when an alternative treatment is available and is not offered as a covered benefit but comes to be considered within accepted practice. Again, it remains the ophthalmologist’s responsibility to offer his or her opinion on these techniques and, if the patient requests, to offer the names of physicians who perform the suggested treatments. It may be advisable for the physician to present new developments to the administration of the managed care organization and to argue the rationale for their inclusion or exclusion. New treatments always have raised ethical and financial dilemmas when benefits and risks have not been defined or where reimbursement mechanisms come into play.

### Conclusion

The continuing changes in health care reimbursement alter relationships among and between physicians, patients, and payors. As new and potentially innovative systems evolve, the ethical obligations of physicians to patients should not be compromised. Regardless of the method of payment, the best interest of the individual patient, rather than economic forces or incentives, should guide the management of his or her care.

#### 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 4. Other Opinions.* Ophthalmologists should be cognizant of the limitations of his/her knowledge and skills and be willing to seek consultations in clinical situations where appropriate. The patient's request for additional opinion(s) should be respected."

*"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 provision 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."

*"Rule 11. Commercial Relationships.* An ophthalmologist's clinical judgment and practice must not be affected by economic interest in, commitment to, or benefit from professionally related commercial enterprises."

*"Rule 14. Interrelations Between Ophthalmologists.* Interrelations between ophthalmologists must be conducted in a manner that advances the best interests of the patient, including the sharing of relevant information."

*"Rule 15. Conflict of Interest.* A conflict of interest exists when professional judgment concerning the well-being of the patient has a reasonable chance of being influenced by other interests of the provider. Disclosure of a conflict of interest is required in communications to patients, the public, and colleagues."

*"Rule 17. Confidentiality.* An ophthalmologist shall respect the confidential physician-patient relationship and safeguard confidential information consistent with the law."

#### 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 the determining what best serves the interest(s) of patients."

*"Principle 2. An Ophthalmologist's Responsibility.* It is the responsibility of an ophthalmologist to act in the best interest of the patient."

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

*"Principle 5. Communication with the Patient.* Open communication with the patient is essential. Patient confidences must be safeguarded within the constraints of the law."

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

*"Rule 1. Competence.* An ophthalmologist is a physician who is educated and trained to provide medical and surgical care of the eyes and related structures. An ophthalmologist should perform only those procedures in which the ophthalmologist is competent by virtue of specific training or experience or is assisted by one who is. An ophthalmologist must not misrepresent credentials, training, experience, ability, or results."

*"Rule 3. Research and Innovation.* Research is conducted to provide information on which to base diagnostic, prognostic or therapeutic decisions and/or to improve understanding of pathogenesis in circumstances in which insufficient information exists. Research and innovation must be approved by appropriate review mechanisms (Institutional Review Board; IRB) and must comply with all requirements of the approved study protocol to protect patients from being subjected to or potentially affected by inappropriate or fraudulent research. In emerging areas of ophthalmic treatment where recognized guidelines do not exist, the ophthalmologist should exercise especially careful judgment and take appropriate precautions to safeguard patient welfare. Appropriate informed consent for research and innovative procedures must recognize their special nature and ramifications. The ophthalmologist must demonstrate an understanding of the purpose and goals of the research and recognize and disclose financial and non-financial conflicts of interest. Commensurate with the level of his/her involvement, the investigator must accept personal accountability for patient safety and compliance with all legal and IRB-imposed requirements."

"Rule 12. *Communications to Colleagues.* Communications to colleagues must be accurate and truthful."

"Rule 13. *Communications to the Public.* Communications to the public must be accurate. They must not convey false, untrue, deceptive, or misleading information through statements, testimonials, photographs, graphics, or other means. They must not omit material information without which the communications would be deceptive. Communications must not appeal to an individual's anxiety in an excessive or unfair way, and they must not create unjustified expectations of results. If communications refer to benefits or other attributes of ophthalmic procedures that involve significant risks, realistic assessments of their safety and efficacy must also be included, as well as the availability of alternatives and, where necessary to avoid deception, descriptions and/or assessments of the benefits or other attributes of those alternatives. Communications must not misrepresent an ophthalmologist's credentials, training, experience, or ability, and must not contain material claims of superiority that cannot be substantiated. If a communication results from payment by an ophthalmologist, this must be disclosed unless the nature, format, or medium makes it apparent."

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