

## **ADVISORY OPINION OF THE CODE OF ETHICS**

**Subject:** **Unnecessary Surgery and Related Procedures**

**Issues Raised:** Under what circumstances are surgery and related procedures considered unnecessary?

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

### **Background**

Recommending or performing unnecessary surgery is inconsistent with ethical practice, because all surgical procedures bear some degree of risk. Performing unnecessary surgery is a major betrayal of the surgeon's paramount obligation to place the patient's best interests first in therapeutic decisions.

Surgeons have a responsibility to evaluate all of the procedures they perform and to consider whether they are appropriate for a particular patient. Conversely, if a procedure is likely to be significantly beneficial to the patient, medically justified, and desired by the patient, a surgeon should not ordinarily decline to execute a procedure he or she is qualified to perform.

Performing unnecessary surgery violates rules 6 and 10 of the Academy's Code of Ethics. It may also violate rules 2 and 9, which require that the surgeon fully advise the patient about the proposed surgical procedure; the reasons for proposing it; and any substantial risks, benefits, and alternatives. These rules also require that after the patient is informed and understands this critical information, he or she voluntarily consents to the surgery. Behind nearly every case of unnecessary surgery, there was a failure to obtain adequate information about the risks, benefits, and alternatives or the ophthalmologist may have even made actual misrepresentations. Clearly, these are serious ethical violations.

Performing unnecessary surgery may be a basis for malpractice liability or tort actions for fraud and battery. Knowingly claiming reimbursement for unnecessary surgery could also constitute fraud under Medicare/Medicaid or private insurance policies. A pattern or practice of performing a high volume of certain kinds of surgery on populations whose clinical need for such surgery is suspect may also suggest the existence of unethical practice and become a subject of scrutiny.

Although the ethical standard with respect to unnecessary surgery is clear, it may be difficult to identify which cases are unnecessary. For our purposes, unnecessary surgery is that which is clearly unjustifiable when the risks and costs exceed the likely therapeutic

benefits to the patient based on the patient's lifestyle requirements. No one factor alone can determine whether a particular surgery is unnecessary; instead, the patient's quality of life must be taken into account. Unnecessary surgery is not an isolated, clinically observable phenomenon. A cataract operation on a 65-year-old man who reports that he sees just fine for his needs might be unnecessary, while a similar cataract in a 55-year-old school bus driver might require surgery.

It should be stressed that the surgeon's decision to recommend surgery, made in close consultation with the patient and subject to the patient's consent, is a complex one. Well-qualified and reasonable surgeons can differ as to the need for surgery in certain situations. While some cases are clear, others continue to incur lively professional debate over whether conservative or aggressive approaches are best. For ethical purposes the term "unnecessary surgery" should be applied only where (1) in an individual case there is a decision to perform surgery that is beyond the range of reasonable judgment in light of the patient's needs and is substantially inconsistent with accepted professional standards for determining the need for surgery, and/or (2) there is a pattern or general practice of performing surgery in what would generally be considered marginally justifiable cases. The following examples illustrate these concepts.

### **First Inquiry**

*Facts* - Dr. T is a well-known cataract /intraocular lens (IOL) implant surgeon who is currently involved in an active research program on an innovative lens implant that has theoretical advantages for scotopic vision over current designs. He is currently recruiting patients for a clinical trial. He sees a 60-year-old taxi driver who has a relatively insignificant nuclear cataract. The patient reports that he experiences some glare under certain conditions such as night driving, but that recently he had requalified for a drivers' license and can drive comfortably. He states that he does not want the operation, but Dr. T strongly advises him to have it and ultimately persuades him.

*Resolution* - Dr. T may have acted unethically. It appears that the patient did not think that the cataract was interfering with his occupation or lifestyle. A decision to defer surgery would have borne no significant risks in this case. Surgery for a nonvisually limiting cataract in a 60-year-old man would not ordinarily be justified unless the patient thought his occupational needs or lifestyle was significantly impaired, and the surgeon concluded that the cataract was the cause of the impairment. Thus, medical justification for the surgery seems to be lacking in this case. If Dr. T's real motivation is to recruit another case for the series that is to be the basis for his research, then he is clearly placing his own research interests above those of the patient and is acting unethically. Even if this is not Dr. T's conscious motive, he should be aware of the patient's vulnerability and how easily the patient can be coerced into making a decision with which he is uncomfortable. In such a case, the patient's consent is not voluntary and informed but rather the result of implicit or explicit coercion.

### **Second Inquiry**

*Facts* - Dr. S is an experienced ophthalmologist who has cared for a 60-year-old patient with advanced chronic open-angle glaucoma. He has documented visual field loss and progressive cupping of the optic disc in spite of treating her with the maximum medication she can tolerate. Dr. S strongly recommends filtration surgery, which he advises has some risks but may reduce the risk of further visual loss. The patient at first hesitates, saying that she has not noticed pain or visual loss and does not think that she needs an operation. After Dr. S explains his findings, the risks of permitting the disorder to remain uncontrolled despite medical treatment, and the potentially less optimal results of

alternative treatment (e.g., laser trabeculoplasty surgery), the patient consents to filtration surgery.

*Resolution* – Although Dr. S vigorously advocates surgery over the patient's initial objection, he appears to have acted ethically. He has examined the patient; detected progressive disease; and accurately outlined for the patient the therapeutic options, benefits, and risks. The fact that the patient did not previously perceive the need for surgery and initially was not sure she wanted it does not make the surgery unnecessary given the serious medical justification (progressive visual loss) for it. If medical justification for surgery exists and appropriate informed consent is ultimately obtained, it is not unnecessary. When a surgeon suggests that a patient consider more elective surgery, the element of informed consent that is at issue is frequently voluntary choice (vs. coercion). This is especially true when the patient has a long-term, trusting relationship with the surgeon. Therefore, the surgeon must make every effort to ensure that the patient understands what is being proposed.

### **Third Inquiry**

*Facts* - Dr. C is a very capable cataract surgeon with an active practice, who was sued 2 years ago for malpractice in a case concerning corneal edema and cystoid macular edema. Although he successfully defended his case, he resolved to perform specular microscopy pachymetry and fluorescein angiography before surgery in every case, in an effort to better defend himself in the event of future lawsuits.

*Resolution* - Dr. C appears to have adopted an unethical practice. It is ethical for an ophthalmologist to decide to utilize all appropriate diagnostic procedures in a particularly difficult case, where they may be necessary to confirm or eliminate difficult diagnostic questions. However, the range of diagnostic procedures that are appropriate to particular cases varies, and the choice of which to use must be made on an individualized basis. This is an example of "defensive medicine" for legal purposes. This practice is especially unethical, because some diagnostic procedures (e.g., fluorescein angiography) bear a degree of risk to the patient. Since the patient must bear these risks (and perhaps some of the costs), the ophthalmologist should not use these procedures unless he or she concludes that the benefits to the patient outweigh the risks. Otherwise, the ophthalmologist has placed his or her own interests above those of the patient, and this is unethical.

### **Fourth Inquiry**

*Facts* - Dr. R is an experienced corneal transplant surgeon who maintained an excellent reputation for many years. In recent years, his practice has been somewhat less active. Dr. R decided 2 years ago that he did not believe in newer lamellar procedures (e.g., Descemets stripping keratoplasty, DSEK) to treat corneal edema. He candidly tells all of his Fuchs' Dystrophy patients that he thinks these newer procedures are not reliable, and that they will be better served if he performs a conventional penetrating keratoplasty.

*Resolution* - Dr. R presents the converse of unnecessarily aggressive surgery: possibly inappropriate conservatism. There is nothing wrong with a surgeon limiting his/her practice to those types of procedures he or she believes in and feels confident in performing. It is ethical to inform patients as to why he or she does or does not believe in employing particular techniques or devices. However, if an ophthalmologist is not prepared to consider all reasonable alternative therapies that might be beneficial, it is critical that he or she inform the patient. The ophthalmologist should take great care to ensure that the patient is fully informed about the alternatives, including those that could be provided by other qualified physicians. Therefore, if Dr. R informs all of his patients that they will be better off without DSEK, he is probably not rendering justifiable medical advice. Moreover, if he performs conventional penetrating keratoplasty on all of his patients, including those who

most corneal surgeons would consider good candidates for DSEK, he may be acting unethically. He would be performing surgery without disclosing alternative techniques and explaining honestly why he was suggesting a surgical approach based on personal reasons that may not be consistent with acting in the patients' best interests. If the pattern of such practices constituted a substantial departure from generally recognized contemporary medical standards, and particularly if patients were not fully advised about alternatives, Dr. R would be acting unethically.

### **Applicable Rules**

*"Rule 2. Informed Consent.* The performance of medical or surgical procedures shall be preceded by appropriate informed consent."

*"Rule 6. Pretreatment Assessment.* Surgery shall be recommended only after a careful consideration of the patient's physical, social, emotional, and occupational needs. The ophthalmologist must evaluate the patient and 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 9. Medical and Surgical Procedures.* An ophthalmologist must not misrepresent the service that is performed or the charges made for that service."

*"Rule 10. Procedures and Materials.* Ophthalmologists should order only those laboratory procedures, optical devices, or pharmacological agents that are in the best interest of the patient. Ordering unnecessary procedures or materials, or withholding necessary procedures or materials, is unethical."

### **Other References**

*American Academy of Ophthalmology Advisory Opinions of the Code of Ethics, Informed Consent.*

42 U.S.C. §139y(1)(B)

42 C.F.R., § 420.101(a)(2)

American Medical Association, Current Opinions of the Council on Ethical & Judicial Affairs Section 4.06 "Physician-Hospital Contractual Relations," Section 8.07 "Informed Consent."

American College of Surgeons, Statements on Principles, II.G "Unnecessary Surgery is Condemned."

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