



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; patient choice; and other considerations. 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 only general guidance. 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. S is a 70-year-old man whose ophthalmologist told him that his decreasing vision was due to age-related macular degeneration. When Mr. S 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. S that the cataracts were not of sufficient density to be causing the decline in vision he reported.

A month later, Mr. S visited his sister in a distant city. Through newspaper and television ads, Mr. S learned of Dr. A, an Academy Fellow, and went to see him. After examining Mr. S, 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. S's macular degeneration. Surgery was scheduled. Dr. A operated on one of Mr. S's eyes one day and on the second eye the next day. A few days later, Mr. S returned home and received follow-up care from his primary ophthalmologist. Examination revealed no visual improvement at 1 month and 3 months postoperatively. Mr. S is angry, and he has inquired whether Dr. A acted ethically.

Resolution — It is highly improbable that Mr. S'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 (although it is theoretically possible). 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. S about the results of the examinations performed only 1 month prior, or that he attempted to obtain the examination records from Mr. S's local ophthalmologists.

By virtue of his failing to diagnose macular degeneration and consider it as the most likely cause of Mr. S's decreased vision, Dr. A incorrectly informed Mr. S 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 not have provided adequate postoperative care, in violation of Rule 8 of the Code of Ethics. It is not standard practice to perform surgery on the second of Mr. S's eyes without waiting for a postoperative assessment on the first eye. Additionally, 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.

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. J, 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 — It is extremely difficult to generalize about what procedures are necessary and what procedures are unnecessary. There may be many patients for whom even the generalizations would be irresponsible practice. 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 comfortably and competently manage their patients.

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 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 cases 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, the procedure is 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 has clearly 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. 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 pecuniary 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. T, a 78-year-old woman, comes to the office of Dr. G, saying that she wonders how her eyes are. 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 mm Hg 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. T 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. T 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 has acted unethically in the care that he has provided to Mrs. T. 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 medically-unstable patient whose intraocular pressure is not excessively high and has no clinical appearance of glaucomatous optic nerve damage, and no risk factors for glaucoma is typically not warranted. 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 glaucoma treatment in this case appears to far outweigh the potential benefits, the patient was given erroneous information about “proof” of her disease, and in addition has developed a known side-effect of the chosen treatment, the patient 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. T’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. The performance of medical or surgical procedures shall be preceded by appropriate informed consent. When obtaining informed consent, pertinent medical facts and recommendations consistent with good medical practice must be presented in understandable terms to the patient or to the person responsible for the patient. Such information should include alternative modes of treatment, the objectives, risks, and possible complications of such a treatment, and the consequences of no treatment. The operating ophthalmologist must personally confirm with the patient or patient surrogate their (his or her) comprehension of this information."

"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 assure 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 only those laboratory procedures, optical devices or pharmacological agents that are in the best interest of the patient. Ordering unnecessary procedures or materials for pecuniary gain is unethical."

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 determination that the best interests of patients are served."

"Principle 2. Providing Ophthalmological Services. Ophthalmological services must be provided with compassion, respect for human dignity, honesty and integrity."

Principle 5. Fees for Ophthalmological Services. Fees for ophthalmological services must not exploit patients or others who pay for the services.

42 U.S.C. SEC. 1396y(1)(B); 42 C.F.R. SEC. 420.101(a)(2); *AMA Opinions of the Judicial Council*, SEC. 8.06 ("Drugs and Devices: Prescribing"), SEC 8.08 ("Laboratory Services"); *American College of Surgeons, Principles of Qualifications for Fellowship*, SEC. G. ("Unnecessary Surgery is Condemned"); *American Academy of Ophthalmology Ethics Advisory Opinion "Unnecessary Surgery and Related Procedures."*

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