WOLFE: World Ophthalmology Leaders Forum in Education
A Forum of the American Academy of Ophthalmology 2012 Annual Meeting in Chicago
Professionalism in Ophthalmology—A Global Conversation

WOLFE

This year’s meeting was presided over by Ronald E. Smith, MD, Secretary for Global Alliances, who provided a brief history of WOLFE and a list of topics covered since its inception in 2005:

2005  Attaining Clinical Knowledge and Skills in a Global Environment
2008  Principles and Practices of Resident Education Around the World
2009  Teaching Surgical Skills to Trainees Today and Tomorrow
2010  Global Quality of Care Forum
2011  Global Optometry: Changing and Challenging, Non-Physician Providers – Lessons Learned Around the World
2012  Professionalism in Ophthalmology – A Global Conversation

Reports from these meetings are available at:
http://www.aao.org/international/wolfe/wolfe-archives.cfm

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Introduction: Professionalism in Ophthalmology – A Global Conversation

Dwindling health care budgets emerged as a concern during this year’s World Ophthalmology Leaders Forum in Education (WOLFE) meeting. Despite variations in the economic status of individual nations, it was evident that ophthalmologists around the world are grappling with financial constraints and are deeply concerned about the impact that limited resources are having on the provision of eye care.

In this challenging environment, they are also particularly determined to make the most of what they have to offer for the welfare of their patients. In other words, distributive justice—one of the hallmarks of ethical medical care—remains a touchstone in ophthalmology.

These and other ethical considerations were the focus of this year’s meeting, “Professionalism in Ophthalmology—a Global Conversation.” From protecting patients’ rights in clinical research to finding ways to do away with onerous waiting lists, speakers outlined their perspectives on the intersection of professionalism and ethical behavior.

As economic realities stimulate re-examination of how to deliver quality, efficient care, codes of ethics help focus attention on our highest priority—protecting the interests of each individual patient. A code of ethics should be a living document, balancing enduring standards with contemporary needs, noted Charles Zacks, MD, who served as program moderator and past chair of the AAO Ethics Committee. However, achieving consensus on what constitutes ethical conduct and on how to teach standards of conduct presents multiple challenges. He asked several questions: Is there a need for a global consensus on the issues of ethics and professionalism? Are there specific standards of conduct that must be cited? Should coordinated programs be developed to promote ethics? Indeed, do ophthalmology leaders bear a responsibility to teach these ideas?

If the answers to those questions are affirmative, then additional practical considerations must be addressed, from defining standards to promoting and enforcing them.

Throughout medicine, organizations have agreed that codes of ethics are valuable documents that can be used for education, policy development, and enforcement, Dr. Zacks said. A code of ethics articulates “shared standards and can be used to sanction colleagues that willfully violate those standards.” The World Health Organization has developed standards for medicine as a whole; within ophthalmology, physicians can turn to codes of ethics developed by the American Academy of Ophthalmology and the International Council of Ophthalmology.

In providing an overview of the AAO’s ethics code and program, Dr. Zacks noted that establishing an ethics committee signals a commitment to “professionalism, transparency, and responsibility” in the eyes of the public at large, patients, and policy makers and called on the international attendees to share their experiences and exchange ideas for new initiatives.

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New Zealand has a socialized medical system that provides free health care to each of the country’s residents. However, demand for care far outstrips supply, and not all services are available in all geographic areas, said Stephen J. Best, MBChB, FRANZCO. “We are very much limited by our financial resources.”

As a result, waiting lists became the de facto rationing tool. “People were put on a list and just waited until their turn came up,” Dr. Best said. Prior to the mid-1990s, waiting lists for elective procedures were often quite long. A cataract patient, for instance, might wait as long as two years for surgery. Disgruntled patients placed pressure on the government to speed up the waiting game—and the government listened.

What’s Your Score?
The solution, developed in 1996, is the Clinical Priority Access Criteria (CPAC). While CPAC has not done away with waiting lists altogether, it has shortened them significantly. “Elective surgery is now to be performed within six months of acceptance onto a waiting list,” Dr. Best said, and the pressure is on to decrease that time even further.

Under the CPAC system, cataract patients are referred by general practitioners or optometrists to ophthalmologists, who then score them based on their clinical need, up to 100 possible points. As a patient is evaluated, a number of factors are taken into account for the total score. The cataract CPAC accounts not only for the best corrected visual acuity for each eye and severity of visual impairment but also for social factors, such as the patient’s ability to work and live independently.

If the total score is above the threshold set by the local District Health Board (DHB), the patient is placed on the waiting list, with surgery to occur within six months. Patients with the highest scores are moved to the head of the line, Dr. Best said. “This ensures that severe cases get more urgent treatment.”

Average scores vary by region, as do thresholds. In Dr. Best’s area, the typical score for a cataract patient is 23 to 25 points. Other areas have higher scores, in part because of ethnic variations. “Pacific Islanders often present very late, and they often present with white cataracts,” he said.

Imperfect but Reasonable
Overall, the CPAC system is a reasonable attempt at fair and equitable rationing, Dr. Best said. However, it should be noted that there is some degree of subjectivity and significant potential for manipulation.

CPAC scoring relies on ethics and integrity, not only from the surgeon, but also the patient. “You have to be careful about interviewing patients,” Dr. Best said. And while the system theoretically should result in equal access to care no matter where a patient lives in New Zealand, score thresholds are manipulated by the local DHBs to comply with the six-month requirement.
Moreover, clinical over riders may be employed to alter scores. For instance, a patient’s score may be lowered if he or she has a pre-existing condition that is likely to have a negative impact on the outcome of cataract surgery.

That said, patients are on equal footing whether or not they have private or public insurance, Dr. Best said. “I can say to the patient, ‘You have the same access to care based on your score, whether I see you privately or publicly.’”

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**Pan America**

*Ethics in Clinical Research: An Overview*

**Neeru Gupta, MD, PhD, MBA**

*President of the Canadian Glaucoma Society*

Clinical research is fundamental to major advances in patient care. But because of the inherent risks to study participants, the ethical components of a trial are equally as important as the operational and analytical components, said Neeru Gupta, MD, PhD, MBA.

“As residents, most of us didn’t get training in the ethics in clinical research,” said Dr. Gupta, “yet the outcome of work done in clinical trials is what we’re practicing every day.”

**Critical Considerations**

Ethical behavior in clinical research is under continuous evolution and study, Dr. Gupta said. “It is a constant self-monitoring process.” At present, the following precepts are widely accepted.

**# Establish scientific validity.** Before enrolling patients in a clinical trial, the researcher must ask him- or herself three questions, Dr. Gupta said: 1) Is the study designed to answer the question? 2) Are the measurements standardized? 3) Does the study have validity? If the answer to any of these is “No,” then “Go no further,” she said.

**# Protect the patient.** If you decide to proceed, the health of the patient must be your first consideration. (See the [WMA Declaration of Helsinki - Ethical Principles for Medical Research Involving Human Subjects](http://www.wma.net/en/30publications/10policies/b3/).

**# Disclose conflicts.** All conflicts of interest must be disclosed. “When there are incentives built into research, they must be kept in mind,” Dr. Gupta said.

**# Obtain informed consent.** The researcher must fully disclose all known and potential risks, and the patient must be capable of making a fully informed decision, Dr. Gupta said. She emphasized that patient participation is voluntary: “The patient needs to be assured that declining or opting out will not alter the physician/patient relationship,” she said.

Dr. Gupta emphasized that a patient’s decision to opt out of participation is “a fundamental right. Regardless of how critical that moment in the trial is, it’s our duty to understand what has happened and why the patient wishes to withdraw.”

**Three Principles**

Essentially, the researcher must adhere to the three ethical principles of respect, beneficence, and justice, as outlined in the [Belmont Report](http://www.hhs.gov/ohrp/policy/belmont.html). Under that ethical umbrella, the following must be considered, Dr. Gupta said:
# Respect. The patient must know the purpose of the trial, the primary procedures under investigation, all risks and possible benefits, any alternatives to participating, and the methods that will be used to protect his or her confidentiality.

# Beneficence. The risks and benefits of the drug or procedure must be examined; in addition, the risks must be reasonable and minimized. Valid research methods must be ensured, and there must be sufficient knowledge to assess the study.

# Justice. There should be equitable distribution of both the benefits and the burdens of research across populations. “Those who have greater access to wealth shouldn’t necessarily have greater access to experimental therapies,” Dr. Gupta said. Moreover, vulnerable individuals should receive protection and oversight, so that abuses similar to those of the past are not repeated.

**Bottom Line**

It’s essential to remember that patients who enroll in trials “are a unique subset of patients,” Dr. Gupta said. “They wish to broaden the scope of care and contribute in some way.” She emphasized that patients in trials are at increased risk and need to be fully aware of all the risks and benefits of the treatment under study and called for “open communication and strong understandings” between researchers and patients.

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**Europe**

**Reconfiguring Eye Care Delivery In Ireland**

**Paul Moriarty, LRCP&SI, MBBCh, FRCS**

Former President, Irish College of Ophthalmologists

The collapse of the “Celtic Tiger” is reshaping how eye care will be delivered in Ireland. Thanks to substantive cost overruns and intense political pressure to trim money from the health care budget, Irish ophthalmologists are facing several significant changes, including cuts in residency positions and greater use of allied professionals, said Paul Moriarty, LRCP&SI, MBBCh, FRCS.

**Three Stages of Change**

The revision is being undertaken in three stages, said Dr. Moriarty:

# Analysis. Stage 1 will involve an analysis of how care is currently being delivered, including who provides what care at what cost.

# Literature review. Stage 2 will involve a review of the published literature on service provision, including skill mix and emerging technologies.

# Models of care. Stage 3 will involve modeling alternative pathways of care throughout the country.

At present, “We are really in the planning stage,” said Dr. Moriarty. Five major subspecialty areas—cataract, glaucoma, pediatric amblyopia screening, age-related macular degeneration (AMD), and diabetes—are being scrutinized. Glaucoma and AMD are the costliest conditions, he said. “By evaluating these, we can see how the program will be structured.”
O Brave New World
Aims of reconfiguration include greater use of allied professionals, allowing surgeons more time to practice surgery, and beefing up community care, so that patients don’t need to travel for postsurgical care, Dr. Moriarty said.

But these changes need upfront funding, he said. Otherwise, redistribution of funding during the reconfiguration process will actually weaken the new structure.

Other risks of the reconfiguration include a dilution of the physician-patient relationship and the increased status of optometrists, with subsequent challenge to physician authority.

Potential Savings
The following areas have been identified as having the greatest potential for savings:

# Manpower. The overall number of basic resident positions is expected to be cut by half, with the number of senior surgical trainees reduced by one-third, Dr. Moriarty said. This is expected to release money that will be used to fund permanent posts within the system, possibly in community clinics, he said.

# Drugs. Some savings will come from greater use of generics and bulk purchasing of common medications. (However, savings are expected to be minimal—approximately 10 percent—because of existing governmental agreements with drug companies.) With regard to the treatment of AMD, the less-expensive Avastin (bevacizumab) remains off label in Europe, and Novartis is exerting legal pressure to keep it that way. As a result, national drug advisory boards are not able to give guidelines that include the use of Avastin.

# Devices. Bulk purchase options, particularly with intraocular lenses (IOLs) are being considered, Dr. Moriarty said. However, as with drugs, cost savings will likely be minimal—the Irish Department of Health has a central purchase office, but inefficiencies and administrative costs may wipe out any potential savings. Nonetheless, the array of IOL options is expected to narrow.

# Pathways of care. As ophthalmologists are expensive and in short supply, alternative patterns of care are essential, Dr. Moriarty said. “Tasks may be allocated according to skill sets,” he said.

For instance, pediatric cases of amblyopia may be diverted to orthoptic and optometric teams once ophthalmologists rule out the presence of any other ocular disease. “We are overwhelmed by amblyopic children,” he noted, and patients often find themselves waiting for up to two years before they are treated. “It may take 12 to 18 months for the initial consultation to take place, and then there’s another wait of six months for them to get care.”

With regard to trauma, skilled ophthalmic nurses would perform triage and provide care according to set protocols. With regard to glaucoma, the care of patients with stable disease would be managed by optometrists and community ophthalmologists.

Pilot Studies
A study currently under way is evaluating optometric referral and postoperative care for cataract patients. It is hoped that this will eliminate waiting times for initial consultation, Dr. Moriarty said.

A second study, which is in the development stage, would evaluate the care of AMD patients. In this study, follow-up care would be provided by optometrists, using photographs and OCT.
The Buck Stops Here
Ophthalmologists will still be the “professional hub of the eye care system,” Dr. Moriarty said. In practical terms, that may mean that Eye MDs will find themselves more involved in planning and managerial oversight, he said. “We are moving toward a more corporate structure, as opposed to individual practitioners.”

But the bottom line is that “at the end of the day, the buck stops with the doctors,” he said. Despite the new reality that certain tasks will be delegated to other care providers, “physicians, who are the hub of the decision-making process, must not delegate responsibility.”

This will allow Ireland’s ophthalmologists to maintain their ethical and professional standards and their roles as physician advocates.

And to protect those standards, ethical teaching to residents is being expanded, Dr. Moriarty said. “Like Caesar’s wife, our professional standards must be above suspicion.”

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Europe
Eastern Europe: Limited Resources for Eye Health
János Németh, MD, PhD, DSc
President, Hungarian Ophthalmological Society

The problem of limited resources is pervasive throughout Eastern European countries, leading to such challenges as a lack of treatment options for certain conditions or unacceptably long waiting lists for others. These problems destroy the basic principles of universal access to health care, human rights, and equity, said János Németh, MD, PhD, DSc.

Treatment
Dr. Nemeth provided an overview of the current funding inequities by focusing on two areas of treatment:

# Cataract surgery. Technical and surgical levels of care are uneven throughout the region. In some countries, only the private sector provides high-quality cataract surgery, which restricts care to those who are able to pay for the surgery and the intraocular lens (IOL). In other countries, while both the private and public sectors are able to provide the current standard of care (small-incision cataract surgery with foldable IOLs), those who are covered under the public program face long waiting lists of up to three years in length.

# AMD. Similar problems face those who have age-related macular degeneration (AMD). In many countries, anti-VEGF treatment is not covered under public programs; in others, patients face unacceptably long waiting lists of up to nine months. Thus, patients must either go abroad for care or be willing to pay out of pocket. Some patients have pursued off-label treatments; others have gone blind while waiting for care, Dr. Nemeth said.

Prevention
While preventive care would undoubtedly save patients’ sight and lower overall treatment costs, no nationwide screening programs exist in Eastern Europe for such significant conditions as
diabetic retinopathy, glaucoma, and retinopathy of prematurity. But even if screening were available, treatment might not be readily available, depending on the country, Dr. Nemeth said.

**Research Funding**
Limited finances also limit the support of vision research, and the region has a low rate of published scientific studies. Eastern Europe also is affected by a “brain drain,” which curtails research. Moreover, the region’s ophthalmologists have a low rate of participation in international ophthalmic and other professional and scientific organizations.

**Looking Ahead**
One positive sign for the future of the profession is the success of the meetings of SEEOS (the South-East European Ophthalmological Society) and its related organization, SEE-ARVO (South-East European Association for Research in Vision and Ophthalmology). These professional organizations can provide resources for patient referrals, among other issues, he said. These professional organizations are the basis of the on-site networking of eye specialists and researchers and can also provide resources for patient referrals, among other issues, he said.

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**Sub-Saharan Africa**
Teaching Professionalism and Ethics

**Benedictus G.K. Ajayi, MBBS, MHS**
Group Medical Director, Catholic Eye Hospitals, Nigeria

How does one teach professionalism and ethics to residents and fellows? The key tenets of professionalism (altruism, accountability, excellence, duty, honor and integrity, and respect for others) and those of ethics (beneficence, autonomy and surrogacy, honesty, distributive justice, fiduciary responsibility, and compassion) can be summed up by the Golden Rule, Benedictus G.K. Ajayi, MBBS, MHS, pointed out.

With this rule—“Do unto others as you would have them do unto you”—as the foundation of teaching professionalism and ethics, multiple avenues exist for conveying critical information, Dr. Ajayi noted.

**The Overt Approach**
The stated curriculum, as Dr. Ajayi termed it, raises awareness of and defines the importance of professionalism and ethics and ophthalmology. It also clarifies what constitutes unprofessional behavior.

The formal lecture remains a mainstay of the stated curriculum, valued for its ability to transmit knowledge in an efficient, focused manner. In his own experience teaching at the National Postgraduate Medical College of Nigeria, Dr. Ajayi adopted a lecture format “laced with personal experiences, historic court cases and verdicts, fictional examples of ethical challenges, and real-life experiences of ethical violations.”

The new International Council of Ophthalmology residency curriculum also offers educational materials and guidelines on teaching content, Dr. Ajayi noted.
The Covert Approach
What Dr. Ajayi termed “the hidden curriculum”—what residents observe in the behavior of their teachers, and what that reveals about the teachers’ values and beliefs—is equally valuable and should not be overlooked.

During his own years of training in Nigeria, Dr. Ajayi reported, “there was no stated curriculum. We therefore relied exclusively on the actions and behaviors of our teachers for learning the principles of ethics and professionalism.” If one doubts the impact or significance of this hidden curriculum, one has only to look at what residents say or write about their former teachers, he added.

Adjunct Methods of Education
A number of other teaching strategies may be employed, Dr. Ajayi said. These include educational rounds, roundtable discussions, self-assessment tools, service learning projects, and performance evaluations. The use of mentor courses (training residents to become positive role models and mentors for others) and codes of honor also can be instituted.

In addition, the objective structured clinical examination (OSCE) remains a valuable tool, as does the ICO’s ophthalmology surgical competency assessment rubric (ICO-OSCAR).

Dr. Ajayi also recommended the Center for Ophthalmic Educators, for its educational resources for teachers.