2.3.6 Surgical Co-Management

Surgical co-management refers to the practice of allotting specific responsibilities of patient care to designated clinicians. Such arrangements should be made only to ensure the highest quality of care.

When engaging in this practice, physicians should:

(a) Allocate responsibilities among physicians and other clinicians according to each individual's expertise and qualifications.

(b) Work with the patient and family to designate one physician to be responsible for ensuring that care is delivered in a coordinated and appropriate manner.

(c) Participate in the provision of care by communicating with the coordinating physician and encouraging other members of the care team to do the same.

(d) Obtain patient consent for the surgical co-management arrangement of care, including disclosing significant aspects of the arrangement such as qualifications of clinicians, services each clinician will provide, and billing arrangement.

(e) Obtain informed consent for medical services in keeping with ethics guidance, including provision of all relevant medical facts.

(f) Employ appropriate safeguards to protect patient confidentiality.

(g) Ensure that surgical co-management arrangements are in keeping with ethical and legal restrictions.

(h) Engage another caregiver based on that caregiver's skill and ability to meet the patient's needs, not in the expectation of reciprocal referrals or other self-serving reasons, in keeping with ethics guidance on consultation and referrals.

(i) Refrain from participating in unethical or illegal financial agreements, such as fee-splitting.

AMA Principles of Medical Ethics: I,II,IV,V,VI

Background report(s):

CEJA Report 5-A-99 Ethical implications of surgical co-management

CEJA Report 5 – I-99
Ethical Implications of Surgical Co-Management

INTRODUCTION

Resolution 813, which was adopted at the 1998 Interim meeting, requested that the "ethical implications of surgical co-management be studied by the Council on Ethical and Judicial Affairs (CEJA)." In response to this request, the Council offers the following considerations regarding the appropriateness of surgical co-management arrangements.

DEFINITIONS

The term "surgical co-management" refers to the practice of allotting specific responsibilities of patient care to designated caregivers. In the past, surgical co-management arrangements existed in loosely structured forms. For instance, when specialists communicated information regarding broader health implications back to primary physicians and then worked together to provide the needed care, this could have been considered "co-management." Under these informal arrangements, caregivers may not have documented the allocation of responsibilities.[1]

While informal arrangements may still exist, it is now common for caregivers to formalize their surgical co-management arrangements.[2] The increased utilization of surgical co-management has forced stricter requirements on caregivers. For example, most third party payers have identified three components of surgical co-management: preoperative management, surgical procedure, and postoperative management.[3] Caregivers involved in surgical co-management are required to fit their role into one of the three categories when submitting reimbursement claims.

In addition to the different types of arrangements, the setting in which surgical co-management arrangements occur can vary. For example, some settings consist of outpatient surgery centers and clinical facilities that are under one roof. Others have physicians working in cooperation with non-physician caregivers as a referral-only partnership practice,[4] that is, a partnership that is not centrally located.

Regardless of whether the arrangement is formal or informal, or the setting is central or dispersed, the common purpose of "surgical co-management" is to divide patient care between caregivers. This is the understanding of "surgical co-management" used in the report.

ETHICAL CONSIDERATIONS

Any medical practice that divides the responsibilities of providing care among various caregivers, such as surgical co-management, creates a variety of ethical considerations. Physicians involved in surgical co-management arrangements should be familiar with these considerations.

Allocating services according to caregivers' expertise

When surgical co-management arrangements are made between duly licensed physicians, then responsibilities should be delineated according to the scope of the physicians' expertise. Likewise, when physicians enter into surgical co-management arrangements with allied health professionals, each caregiver's responsibility should correspond to his or her qualifications. This position is articulated in Opinion 3.03, "Allied Health Professionals,"

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> Physicians often practice in concert with allied health professionals such as, but not limited to, optometrists, nurse anesthetists, nurse midwives, and physician assistants in the course of delivering appropriate medical care to their patients. In doing so, physicians should be guided by the following principles:
>
> > (1) It is ethical for a physician to work in consultation with or employ allied health professionals, as long as they are appropriately trained and duly licensed to perform the activities being requested; . . .
> > (4) It is inappropriate to substitute the services of an allied health professional for those of a physician when the allied health professional is not appropriately trained and duly licensed to provide the medical services being requested.[5]

It is appropriate for a physician to work in concert with another physician, limited practitioner, or any other provider of health care services provided that the caregiver is permitted by law to furnish such services. The physician's arrangement with the other caregivers should be based on the caregiver's competence and ability to perform the services needed by the patient in accordance with accepted scientific standards and legal requirements.[6]

Coordinating care among various caregivers

Coordinating care among various caregivers allows for joint accountability. It also prevents inadequate or duplicative care and increased costs.[7] Even though different caregivers will be responsible for rendering specific portions of the patient's care, one physician should be ultimately responsible for ensuring that the care is delivered in a coordinated manner.[8] Other caregivers should support this obligation by communicating with this physician.

The patient's treating physicians are responsible for ensuring that the patient has consented not only to take part in the surgical co-management arrangement but also to the services that will be provided within the arrangement.[9] In addition to disclosing medical facts to the patient, the patient should also be informed of other significant aspects of the surgical co-management arrangement such as the credentials of the other caregivers, the specific services each will provide, and the billing arrangement (see below).

Avoiding financial conflicts of interests

<u>Self-referral</u>

Surgical co-management arrangements that are based upon financial considerations raise concerns about self-referral. For instance, it is inappropriate for an orthopedic surgeon to refer his or her postoperative patients to a rehabilitation center to receive postoperative physical therapy if the orthopedic surgeon has a financial interest in the center and does not personally provide care to patients at the center. As stated in Opinion 8.032, "Conflicts of Interest: Health Facility Ownership by a Physician:"

> In general, physicians should not refer patients to a health care facility which is outside their office practice and at which they do not directly provide care or services when they have an investment interest in that facility. The requirement that the physician directly provide the care or services should be interpreted as commonly understood. The physician needs to have personal involvement with the provision of care on site.

There are narrowly defined exceptions to this restriction on self-referral (*e.g.,* true demonstrated need in the community for the facility without the availability of alternative financing) and in those circumstances

mechanisms to decrease the perception of a financial conflict of interest should be employed. Physicians should take care that their surgical co-management arrangements do not violate the ethical or legal restrictions on self-referral.

Fee-splitting

Physicians who participate in surgical co-management arrangements also should avoid financial agreements such as fee-splitting. Fee-splitting is defined as "payment by or to a physician solely for the referral of a patient" and is unethical.[10] This should be interpreted as prohibiting a physician from entering into a surgical co-management arrangement with another physician or allied health professional in return for some financial gain. Referrals to other caregivers should be based only on that caregiver's skill and ability to meet the patient's needs and not on expected further referrals or other self-serving bases. Patients depend on their physicians for unbiased advice. Fee-splitting arrangements, or any other arrangements that provide personal financial gain to the physician, threaten to bias the physician's decision-making and erode the patient's trust.

To avoid even a perceived impropriety with respect to surgical co-management financial arrangements, the Council has previously recommended that the caregivers submit separate bills to the patient. If submitting separate bills is not possible, then any financial arrangement between the caregivers should be disclosed to the patient prior to rendering services.[11]

Protecting confidential medical information

Lastly, physicians who participate in surgical co-management arrangements should employ appropriate safeguards to ensure that confidential information is protected. There is an obvious need for sharing medical information between caregivers involved in surgical co-management. In some arrangements, information is shared via the transfer of the physical medical record. Other arrangements may employ facsimile transmission or use of computerized databases. Regardless of the method through which information is shared, as always, the utmost effort must be taken to protect confidentiality.

CONCLUSION

Surgical co-management arrangements are not unethical *per se*. However, such arrangements tend to elicit concern regarding potential ethical pitfalls. Caregivers who partake in surgical co-management practices should be aware of the pertinent ethical considerations so as to avoid any actual or perceived inappropriateness.

RECOMMENDATIONS

The Council on Ethical and Judicial Affairs recommends that the following be adopted and that the remainder of this report be filed:

> For the purpose of this report, the term "surgical co-management" refers to the practice of allotting specific responsibilities of patient care to designated caregivers. The following guidelines stem from this understanding:
>
> 1. Physicians should engage in co-management arrangements only to assure the highest quality of care.
>
> 2. When surgical co-management arrangements are made between duly licensed physicians, their responsibilities should be delineated according to the scope of the physicians' expertise.

Likewise, when physicians enter into surgical co-management arrangements with allied health professionals, each caregiver's responsibility should correspond to his or her qualifications.

3. Even though different caregivers will be responsible for rendering specific portions of the patient's care, a single physician should be ultimately responsible for ensuring that the care is delivered in a coordinated manner. Other caregivers should support this obligation by communicating with this physician.

4. The treating physicians are responsible for ensuring that the patient has consented not only to take part in the surgical co-management arrangement but also to the services that will be provided within the arrangement. In addition to disclosing medical facts to the patient, the patient should also be informed of other significant aspects of the surgical co-management arrangement such as the credentials of the other caregivers, the specific services each will provide, and the billing arrangement.

5. Physicians should ensure that their surgical co-management arrangements do not violate the ethical or legal restrictions on self-referral.

6. Referrals to another caregiver should be based only on that caregiver's skill and ability to meet the patient's needs and not on expected further referrals or other self-serving bases. Physicians who participate in surgical co-management arrangements must avoid such financial agreements as fee-splitting, which are both unethical and illegal.

7. Physicians who participate in surgical co-management arrangements should employ appropriate safeguards to ensure that confidential information is protected.

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