TMA Board of Councilors Current Opinions

Texas Medical Association
Board of Councilors Current Opinions

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INTRODUCTION

The Board of Councilors serves as the ethical policy making body of the Texas Medical Association. First constituted in 1903, the Board is composed of a Councilor and Vice Councilor from the 15 statewide councilor districts, and has several important functions. These include the interpretation of the Association's Constitution and Bylaws, the granting of charters to county medical societies, and decisions regarding questions of medical ethics. The Current Opinions of the Board of Councilors covers a wide range of topics from abortion to withdrawing life-prolonging medical treatment, and represents a collective judgment in these matters that are intended to aid physicians in their decision making.

The Board of Councilors renders opinions in response to various inquiries including requests from members, component county medical societies, the House of Delegates, and their understanding of current events affecting the practice of medicine. Opinions are based on the American Medical Association Principles of Medical Ethics, current law, and the Board of Councilors' authority to investigate the general ethical conditions pertaining to the practice of medicine in Texas. Opinions of the Board are intended for the guidance of Texas physicians to responsible professional behavior, and supplement the Current Opinions of the American Medical Association Council on Ethical and Judicial Affairs.

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AMERICAN MEDICAL ASSOCIATION PRINCIPLES OF MEDICAL ETHICS

Under the Texas Medical Association Constitution, all members "shall subscribe to the Principles of Medical Ethics of the American Medical Association" hence, the Board of Councilors looks to these Principles as guidance in the rendering of its opinions.

Preamble:

The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsibility to patients first and foremost, as well as society, to other health professionals, and to self. The following Principles adopted by the American Medical Association are not laws, but standards of conduct which define the essentials of honorable behavior for the physician.

I. A physician shall be dedicated to providing competent medical service with compassion and respect for human dignity and rights.

II. A physician shall uphold the standards of professionalism, be honest in all professional interactions, and strive to report physicians deficient in character and competence, or engaging in fraud or deception, to appropriate entities.

III. A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient.

IV. A physician shall respect the rights of patients, colleagues, and of other health professionals, and shall safeguard patient confidences and privacy within the constraints of the law.

V. A physician shall continue to study, apply and advance scientific knowledge, maintain a commitment to medical education, make relevant information available to patients, colleagues, and

the public, obtain consultation, and use the talents of other health professionals when indicated.

VI. A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical services.

VII. A physician shall recognize a responsibility to participate in activities contributing to an improved community and the betterment of public health.

VIII. A physician shall, while caring for a patient, regard responsibility to the patient as paramount.

IX. A physician shall support access to medical care for all people.

ABANDONMENT. The unilateral severance by the physician of the patient-physician relationship without providing an adequate medical attendant or reasonable notice under existing circumstances of the physician's intent to terminate the patient-physician relationship is abandonment and is unethical. (April. 2003)

ABORTION. Policies covering abortions should be designed by medical staffs to safeguard the patient's health or improve her family life situation. They should have due regard for local legal statutes and judicial decrees. Abortion should only be performed in facilities that are properly supervised by a physician, and with hospital facilities available if needed.

It is recognized that abortion may be performed at a patient's request, or upon a physician's recommendation. No physician should be required to perform, nor should any patient be forced to accept, an abortion. Neither physician, hospital, nor hospital personnel shall be required to perform any act violative of good medical judgment or personally held moral principles.

When abortion is requested by a patient, the patient should be informed of the medical nature of the procedure and of its potential consequences, and the operative consent should be obtained in writing from the patient, or when appropriate, from the parent or guardian of a minor patient. When abortion is recommended by a physician, the indications should be stated in the patient's record, and informed consent obtained. When abortion is recommended by a physician, the indication for the procedure should be approved by a consultant knowledgeable in regard to the condition thought to indicate abortion.

Abortion is an operative procedure and should only be performed: (1) by a physician licensed to practice medicine and surgery in the State of Texas; and (2) in pregnancies beyond the first trimester, in a hospital adequately equipped to care properly for unexpected complications.

ACQUIRED IMMUNE DEFICIENCY SYNDROME -- AIDS.

PHYSICIAN TREATMENT OF HIV PATIENT. A physician should accept the responsibility for the care and treatment of a patient with Acquired Immune Deficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV), antibodies to HIV, or infection with any other probable causative agent or AIDS, if the patient has a medical condition that is within the physician's area of specialty or expertise. A physician may refer the patient to an appropriate physician who will accept the responsibility for the care and treatment of the patient if the patient seeks or requires treatment outside of the referring physician's area of specialization, and the referring physician would normally make a similar referral of a patient who seeks or requires similar treatment.

Physicians are dedicated to providing competent medical services with compassion and respect for human dignity.

Physicians are ethically obligated to respect the rights of privacy and of confidentiality of AIDS patients and seropositive individuals.

The applicable law of the State of Texas requires the physician to report to the Texas Department of Health cases of Human Immunodeficiency Virus (HIV) infection as well as cases of Acquired Immune Deficiency Syndrome (AIDS). Although the law does not require a physician to notify a spouse of a positive test result for AIDS or HIV infection, a physician under Texas law may inform a spouse of a

positive test. In addition, the physician should counsel and attempt to persuade the infected patient not to endanger other parties.

A physician who knows that he or she is seropositive should not engage in any activity that creates a risk of transmission of the disease to others.

A physician who has AIDS or who is seropositive should consult knowledgeable colleagues as to which activities the physician can pursue without creating a risk to patients.

These knowledgeable colleagues should insist that the affected physician comply with existing CDC guidelines for preventing transmission of HIV in health care settings. Decrees or decisions concerning limitation of medical practice should also outline provisions for future restrictions of the affected physician's clinical duties if and when the physician poses a significant health or safety risk to himself or to others. The degree of risk is to be determined according to the current medical knowledge regarding the nature, duration, and severity of the risk and the probabilities that AIDS or a related condition will be transmitted and will cause harm or will impair the cognitive abilities of the affected physician.

HIV INFECTED PHYSICIAN -- COMPLIANCE WITH STATE LAW.

The Board has adopted the following guidelines which are intended to comply with state law and Centers for Disease Control guidelines:

1. A health care worker who performs invasive procedures and has reasonable cause to believe he/she is infected with HIV should determine his/her serostatus or act as if that serostatus is positive.
2. If an infected health care worker performs invasive medical procedures as a part of his/her duties, the health care worker shall request that an ad hoc committee be constituted to consider which activities the infected health care worker can continue to engage in without risk of infection to patients. An infected health care worker shall not perform exposure prone invasive procedures unless the health care worker has sought counsel from such ad hoc committee and has been advised under what circumstances, if any, the health care worker may continue to perform the exposure prone procedures. Membership of the ad hoc committee may be composed of, but not necessarily limited to, an infectious disease specialist familiar with HIV transmission risks, the pertinent hospital department chairperson, a hospital administrator, the infected health care worker's personal physician, and the infected health care worker.
3. A confidential review system should also be established by the ad hoc committee to monitor the health care worker's fitness to engage in invasive health care activities. Any restrictions or modifications to health care activities for patient safety should be determined by the ad hoc committee based on current medical and scientific information.
4. Knowledge of the health care worker's HIV status should be restricted to those few professionals who have a need to know. Except for those with a need to know, all information on the serostatus of the health care worker should be held in the strictest confidence.
5. As a general rule or until there is scientific information to the contrary, the health care worker should be permitted to provide health care services as long as there is no identifiable risk of patient infection and no compromise in physical or mental ability of the health care worker to perform the health care procedures.
6. Where restrictions, limitations, modifications, or a change in health care activities are recommended, the ad hoc committee should do its utmost to assist the health care worker to obtain career counseling, job retraining, and financial and social support for these changes.
7. If intra institutional confidentiality cannot be assured, health care facilities should make arrangements with other organizations such as local or state medical societies to serve the functions of the ad hoc committee.
8. An infected health care worker may not perform an exposure prone invasive procedure without first notifying the patient of the health care worker's seropositive status and obtaining the patient's consent to such procedure before the patient undergoes the procedure.

ADVERTISING. It is not unethical for a physician to authorize the listing of his name and practice in a directory for professional or lay use. Physicians should avoid use of statements which are false, misleading, or deceptive, or which assert professional superiority or the performance of a professional

service in a superior manner if the advertising is not readily subject to verification.

Advertising by physicians can benefit patients by providing information which helps patients make choices about their health care needs. Advertising should not contain false or misleading statements, and should not otherwise operate to deceive. Aggressive, high pressure advertising and publicity may create unjustified expectations. Advertising containing testimonials regarding a physician's skill or the quality of the physician's professional services may be misleading or deceptive and therefore unethical.

Texas law makes advertising professional superiority or the performance of professional service in a superior manner if the advertising is not readily subject to verification grounds for disciplinary action against the physician(s) responsible. Any communication, advertising, or publicity distributed on behalf of a physician, group, partnership, or professional association should include the name of at least one physician responsible for its content.

If a physician produces, writes, edits or pays for professional advertisement then the physician is responsible for its content.

ALTERNATIVE MEDICINE. Physicians should withstand the pressure to offer unproven alternative medicine therapies. At the same time, physicians should, if appropriate, inquire about the use of alternative therapies by their patients. Physicians should educate themselves and their patients about the state of scientific knowledge concerning alternative therapy that is being used or whose use is contemplated. Patients who choose to use alternative therapies should be educated as to the hazards that might result from postponing or stopping conventional medical treatment.

CHAPERONES. USE OF CHAPERONES DURING PHYSICAL EXAMS. From the standpoint of ethics and prudence, the protocol of having chaperones available on a consistent basis for patient examinations, where appropriate, is recommended. Physicians aim to respect the patient’s dignity and to make a positive effort to secure a comfortable and considerate atmosphere for the patient; such actions include the provision of appropriate gowns, private facilities for undressing, sensitive use of draping, and clear explanations on various components of the physical examination. A policy that patients are free to make a request for a chaperone should be established in each health care setting. This policy should be communicated to patients, either by means of a well-displayed notice or preferably through a conversation initiated by the intake nurse or the physician. The request by a patient to have a chaperone should be honored. An authorized health professional should serve as a chaperone whenever possible. In their practices, physicians should establish clear expectations about respecting patient privacy and confidentiality to which chaperones must adhere. If a chaperone is to be provided, a separate opportunity for private conversation between the patient and the physician should be allowed. The physician should keep inquiries and history-taking, especially those of a sensitive nature, to a minimum during the course of the chaperoned examination. **(Adopted May 2006)**

COINSURANCE AND DEDUCTIBLES. The Board of Councilors believes it would be unethical for a physician to inflate his or her fee to enable a patient to meet more of the deductible. Likewise, physicians should not increase their usual fees simply because they know the patient's insurance will pay more.

Forgiveness of deductibles or coinsurance for financial hardship does not constitute unethical practice. However, physicians should not routinely waive deductibles or coinsurance to encourage utilization of medical services. Generally, with appropriate claim submission, the physician remains free to determine the level of his or her fees charged for patients not covered by government health programs. **(Modified February 2005)**

COLLECTION PRACTICES. Although harsh or commercial collection practices are discouraged in the practice of medicine, a physician who has experienced problems with delinquent accounts may properly choose to request that payment be made at the time of treatment or add interest or other reasonable charges to delinquent accounts. The patient must be notified in advance of the interest or other reasonable finance or service charges by such means as the posting of a notice in the

physician's waiting room, the distribution of leaflets describing the office billing practices, and appropriate notation on the billing statement. The physician must comply with state and federal laws and regulations applicable to the imposition of such charges. Physicians who choose to add an interest or finance charge to accounts not paid within a reasonable time should make exceptions in hardship cases.

CONFIDENTIALITY. The physician should not reveal confidential communications or information without the express consent of the patient, unless authorized to do so by law.

CONFLICT OF INTEREST—WAIVER. Patients have always expected their physician to do whatever is in the patient's best medical interests. Thus, the physician-patient relationship dictates that physicians have a high duty of loyalty to their patients. This duty, unlike a contractual duty, cannot be waived, even if requested by the patient.

CONSULTATIVE PEER REVIEW. It is not unethical or inappropriate for any county medical society to make a reasonable charge per case to cover the administrative costs (clerical, duplicating, postage, etc.) for insurance claims submitted for Consultative (Peer) Review. Insurance companies are encouraged to reduce such costs by providing multiple sets of review documents on the cases submitted when requested by the reviewing county medical society. County societies which provide such review should consult legal counsel to avoid potential antitrust liability.

COST CONTAINMENT. In November, 1983 the TMA House of Delegates requested members to voluntarily agree to hold fees at then-current levels for one year. That action reflects physicians' commitment to assist in the management of soaring health care costs.

Although the quality of care provided to their patients remains paramount, physicians should strive to provide services in the least expensive setting in which the necessary services can be performed safely and effectively.

COVERAGE OF PRACTICE. Following establishment of a physician-patient relationship, the physician remains responsible for the care of that patient until such time as the physician-patient relationship is ended in a proper and legal manner.

COVENANTS NOT TO COMPETE. Covenants not to compete disrupt continuity of care, deprive the public of medical services, and restrict competition. The Board of Councilors discourages any agreement that restricts the right of a physician to practice medicine. Restrictive covenants are unethical if they are excessive in geographic scope or duration in the circumstances presented, or if they fail to make reasonable accommodation of a patient's choice of physician.

A physician must not be subject to an action for violating a covenant not to compete for continuing to treat patients whom the physician believes will suffer harm if that physician's care must be discontinued in order to comply with the covenant not to compete.

Enforcement of restictive covenants must not interrupt continuity of care for any patient. Every effort must be made to ensure a seamless transition.

DEATH ISSUES.

PRONOUNCEMENT OF DEATH DURING LATE HOURS. Pronouncement of death is a complex question requiring the physician to use judgment and discretion in determining what is appropriate in each instance. The physician's decision to personally pronounce death will depend on the relationship of the physician to the patient and the family.

There is no legal requirement for the presence of a physician to pronounce death.

Certainly, if relatives and family are present and pronouncement of death would serve a "humanitarian interest," a contact between the physician and the patient's family is highly desirable.

The individual physician should be given the latitude to determine the need for physician presence, depending upon the circumstances.

DEATH CERTIFICATE -- CHARGING A FEE FOR COMPLETION. The Board of Councilors feels that it is unethical for a physician to charge a fee for completion of the original death certificate for recording.

PRONOUNCEMENT OF DEATH BY REGISTERED NURSES. Registered Nurses may pronounce death in accordance with applicable provisions of Texas law, but only where the health care facility has written policies. The Board of Councilors recommends that such policies address the following issues:

1. There should be appropriate physician input into the development of pronouncement of death policies.
2. Registered Nurses should receive appropriate education as to the criteria by which death is pronounced.
3. Appropriate information regarding the patient's death should be transmitted to the patient's attending physician and family. Documentation about the pronouncement of death, including the date and time at which death was pronounced, and the nurses finding's which support the determination that death has occurred, should be provided.
4. Registered Nurses should receive appropriate education in dealing with the patient's family.
5. The policy should determine which registered nurses should pronounce death. For example, in a small hospital it may be appropriate for all registered nurses on staff to have this duty. On the other hand, in larger hospitals it may be appropriate to limit this duty to a certain group, i.e., intensive care unit registered nurses.
6. The availability of RNs to pronounce death in other than brain death situations should not result in physicians routinely delegating this task.

DELEGATION OF MEDICAL ACTS. A licensed physician who delegates medical acts to an unlicensed individual should assure that there is no misleading communications to patients that denote or connote licensure when such person is not licensed by the State of Texas.

DRUGS.

ANTISUBSTITUTION LAWS AND GENERIC PRESCRIPTIONS. Prescribing for patients involves more than the designation of drugs or devices which are most likely to prove efficacious in the treatment of a patient. The physician has an ethical responsibility to assure that high quality products will be dispensed to his patient. Obviously, the benefits of the physician's skill are diminished if the patient receives drugs or devices of inferior quality.

DISPOSITION OF SAMPLES. Physicians who dispense controlled substance samples to patients are required by Department of Public Safety regulations to include the following information on the label: (1) the date of delivery or dispensing; (2) the patient's name and address; (3) the physician's name, address, and telephone number; (4) the name of the medication and directions for its use; and (5) cautionary statements if required by law. The Texas State Board of Medical Examiners has suggested that all medications provided to patients from the physicians' office or supply of drugs should be labeled with the same information. Patients will then be protected against possible charges of illegal drug possession.

LABELING. The Texas Pharmacy Act requires that, unless otherwise directed by the practitioner, the label on the dispensing container shall indicate the actual drug product dispensed (either the brand name, or if none, the generic name), the strength, and the name of the manufacturer or distributor.

Physicians should always designate the number of refills the patient should have, and only the number of doses usually required should be prescribed.

The advantages of labeling outweigh objections in almost every instance, but there are occasions when such labeling is inadvisable for psychological or other reasons. The physician must exercise his professional judgment to determine when those extraordinary circumstances exist.

The physician's explanation to the patient regarding the purpose of the prescribed drug and what may be expected from it, together with the public's growing awareness of the harmful and beneficial effects of drugs, will help minimize problems which may occasionally occur.

DRUG TESTING OF MEDICAL STAFFS. Medical staffs have a right and an obligation to ensure that members of their medial staff are both mentally and physically able to practice in a competent manner and that drug testing for reasonable cause is within that purview. Drug testing based on adequate cause should only be undertaken when the medical staff has reasonable policies to ensure confidentiality, accuracy and fairness. Random drug testing is not supportable in the absence of reasonable cause for testing.

DUTY TO DEAL HONESTLY WITH PATIENTS. It is a fundamental ethical requirement that a physician should at all times deal honestly and openly with patients. Patients have a right to know their past and present medical status and to be free of any mistaken beliefs concerning their conditions. Situations occasionally occur in which a patient suffers significant medical complications. In these situations, the physician is ethically required to inform the patient of all the facts necessary to ensure understanding of what has occurred. Only through full disclosure is a patient able to make informed discussions regarding future medical care.

Ethical responsibility includes informing patients of changes in their diagnosis resulting from retrospective review of test results or any other information. This obligation holds even though the patient's medical treatment or therapeutic options may not be altered by the new information.

EXECUTION -- CHEMICAL INJECTION. A physician may be present at an execution by lethal injection for the sole purpose of pronouncing death.

FEE ISSUES.

COMPLETION OF INSURANCE CLAIM FORM. Charging for completing a claims form or summary for payment for physician's services is not unethical if it is done in accordance with local custom, so long as the fee is identified.

DIRECT BILLING AND FEE-FOR-SERVICE. Patients may select from a variety of options to pay for physicians' services, including fee-for-service and prepaid plans. The Texas Medical Association supports the freedom of both patients and physicians to choose which service delivery plan(s) they will participate in based upon free, unsubsidized competition. TMA believes that both society's interest in the cost-conscious utilization of health care resources and the maintenance of the physician-patient relationship are well-served if physicians bill their patients directly for services rendered, where possible.

EXCESSIVE. TMA encourages reporting directly to the Texas State Board of Medical Examiners instances of flagrant overcharging amounting to a pattern of conduct. In addition, TMA strongly supports and encourages cooperation of all TMA members and their county medical societies in notifying the Texas State Board of Medical Examiners of possible illegal activities by physicians, whether or not they are members of organized medicine. TMA also encourages support for subsequent investigation of such conduct by all appropriate law enforcement agencies.

"RETAINER FEES" FOR NURSING HOME PATIENTS. Requests by a physician for payment of extra fees from nursing home patients for services not covered by Medicaid is not prohibited. However, a retainer fee requested for any services which are covered by Medicaid in Texas is a felony and could subject the physician to a fine, imprisonment, or both. Such illegal conduct would also be unethical, and the physician could face disciplinary action.

FEE SCHEDULES. Neither the Texas Medical Association nor any of its component county medical societies may establish any schedule of fees for the medical, surgical and special services of its members. (Reference: TMA Bylaws, Section 18.50)

SEPARATE BILLING FOR HOSPITAL-BASED PHYSICIANS. Hospital-based physicians may bill their patients directly, or may use hospital personnel and facilities to collect their accounts. However, physicians' bills processed by the hospital should clearly separate charges for hospital services from professional charges for services personally rendered by physicians to particular patients. Since Texas law prohibits hospitals and other lay corporations from hiring physicians as employees to practice medicine in most instances, the separation of professional and hospital charges for hospital-based physicians may be desirable. The physician-patient relationship may also be strengthened if patients

remain aware of their physicians' independent status.

FEE SPLITTING. Payment by one physician to another solely for the referral of a patient is fee splitting and is improper both for the physician making the payment and the physician receiving the payment.

The payment for referrals violates the requirement to deal honestly with patients and colleagues. The patient relies upon the advice of the physician on matters of referral.

All referrals and prescriptions must be based on the skill and quality of the physician to whom the patient has been referred or the quality and efficacy of the drug or product prescribed.

Further, the Medical Practice Act, as interpreted by the Office of the Attorney General of Texas, may prohibit the direct division on a percentage basis of a physician's professional income with lay persons or to lay shareholders in a corporation or other business enterprise.

FINANCIAL DONATIONS. In preparing materials for solicitation of financial gifts and donations, a medical organization should not (1) promise preferential treatment to donors or (2) claim to possess or provide any unique or superior techniques of diagnosis or treatment unless such claims are subject to verification.

FINANCIAL INCENTIVES. Financial incentives such as risk pools, withholds, bonuses, deficits, and penalties may place a physician in a conflict of interest between a physician's financial interest and the physician's responsibility to provide necessary care to the patient. A physician can never justify denying medically necessary care. When offered a contract containing financial incentives, a physician should evaluate the contract to determine if the incentives might directly or indirectly induce the physician to limit medically necessary care. As stated in both TMA and AMA ethical opinions, a physician should not participate in any plan that encourages or requires care at below minimum professional standards. Consequently, a physician should not sign any contract containing financial incentives that the physician believes may induce him or her to deny medically necessary care. Physicians must resolve all conflicts to the benefit of the patient.

Patients must be informed of any financial incentives that could affect the type and level of care that the patients receive. This responsibility to inform falls first on the health plan. Physicians should be prepared, however, to discuss with patients any financial arrangements that could affect patient care.

GENETICS: CONFIDENTIALITY AND THE DUTY TO INFORM THIRD PARTIES. Physicians should not disclose information about a patient's genetically transferable disease to third parties without informed consent of the patient. There may, however, be third parties related to the patient who would directly and significantly benefit from being informed of the nature of the patient's disease. When discussing a test result with a patient who has a genetically transferable disease, the physician should counsel the patient on the importance of communicating information about the disease to potentially affected third parties.

GIFTS FROM INDUSTRY. Any gifts accepted by physicians individually should primarily entail a benefit to patients and should not be of substantial value. Accordingly, textbooks and other gifts are appropriate if they serve a genuine educational function. Thus, a physician may accept modest meals at educational presentations conducted by industry representatives. It is unethical, however, for a physician to demand any gift, including modest meals, as a condition of the physician attending an educational presentation by an industry representative. For example, a physician must not require that a pharmaceutical representative bring a physician lunch before meeting with the representative. A physician must not demand any gift for a person accompanying the physician to an educational presentation. The physician may, however, accept modest meals or other gifts if offered by the industry representative, so long as the meal or gift has, or is offered in connection with, a genuine education function. If the physician does accept an appropriate gift offered in connection with an educational presentation, the physician must attend that presentation.

GIFTS FROM PATIENTS. Gifts that patients offer to physicians are often an expression of appreciation and gratitude or a reflection of cultural tradition, and can enhance the patient-physician

relationship. When deciding to accept a patient's gift, the physician must first consider if that act is in the patient's best interest.

Some gifts signal psychological needs that require the physician's attention. Some patients may attempt to influence care or to secure preferential treatment through the offering of gifts or cash. Acceptance of such gifts is likely to damage the integrity of the patient-physician relationship. Physicians should make clear that gifts given to secure preferential treatment compromise their obligation to provide services in a fair manner.

There are no definitive rules to determine when a physician should or should not accept a gift. No fixed value determines the appropriateness or inappropriateness of a gift from a patient; however, the gift's value relative to the patient's or the physician's means should not be disproportionately or inappropriately large. One criterion is whether the physician would be comfortable if acceptance of the gift were known to colleagues or the public.

Physicians should be cautious if patients discuss gifts in the context of a will. Such discussions must not influence the patient's medical care.

If, after a patient's death, a physician should learn that he or she has been bequeathed a gift, the physician should consider declining the gift if the physician believes that its acceptance would present a significant hardship (financial or emotional) to the family.

The interaction of these various factors is complex and requires the physician to consider them sensitively. **(Adopted May 2005)**

HEALTH FACILITY OWNERSHIP, INCENTIVE PAYMENTS AND CONFLICTS OF INTEREST. It is not unethical, as a general rule, for a physician to own or have a financial interest in a for-profit hospital, nursing home, or other health facility, such as a free-standing surgical center or emergency clinic, even where the physician refers patients to such facility. The Board of Councilors recognizes that many health care facilities would not exist and that many medical services would not be available to patients except for the fact that responsible physicians invested in these facilities and services, thereby rendering a valuable public service. Such actions are consistent with the Principle of Medical Ethics that physicians recognize an ethical responsibility to participate in activities contributing to an improved community. However, when the holding of such business interests is influenced more by profit motive than appropriate patient care, such actions are unethical.

However, due to the potential for abuse of such arrangements, the Board of Councilors recommends that physicians be mindful of the following considerations:

Resolve conflicts of interest. The prime objective of the medical profession is to render service to humanity; reward or financial gain is a subordinate consideration. Under no circumstances may the physician place his own financial interest above the welfare of his patients. For example, it would be unethical or a physician to unnecessarily hospitalize a patient or prolong or reduce a patient's stay in the health facility for the physician's financial benefit. When a conflict develops between the physician's financial interests and the physician's responsibilities to the patient, the conflict must be resolved to the patient's benefit.

Additionally, a physician should not be influenced in the prescribing of drugs, devices, or appliances by a direct or indirect financial interest in a pharmaceutical firm or other supplier. Whether the firm is a manufacturer, distributor, wholesaler, or repackager of the products involved is immaterial. Reputable firms rely on quality and efficacy to sell their products under competitive circumstances and do not appeal to physicians to have financial involvements with the firm in order to influence their prescribing. Thus, a physician may own or operate a pharmacy if there is no resulting exploitation of patients.

Furthermore, any remuneration or return on investment should be based on the physician's percentage of capital investment and not on utilization, or the volume or value of referrals of patients to a particular facility. It is not unethical for a physician to recover his or her investment in such a facility and earn a reasonable rate of return.

Do not engage in fee splitting. Payment by one physician to another solely for the referral of a patient is fee splitting and is improper both for the physician making the payment and the physician receiving

the payment.

Fee splitting violates the requirement to deal honestly with patients and colleagues. The patient relies upon the advice of the physician on matters of referral.

All referrals and prescriptions must be based on the skill and quality of the physician to whom the patient has been referred or the quality and efficacy of the drug or product prescribed.

The Board of Councilors reminds physicians that fee splitting is a violation of TMA Bylaws and may subject a member to disciplinary action.

Ensure that the facility renders the best possible service. The Board of Councilors believes that the physician's ethical duty to place the patient's interest above his own interest is served where the health care facility to which the physician refers patients has an effective quality assurance and utilization review program to assess the quality of care provided and guard against unnecessary utilization. Additionally, the Board of Councilors believes that the opportunity for abuse is lessened when the investing physician refers patients to a health care facility in which the physician will personally render medical care to the patient. While these are not absolute requirements, they are examples of indicia that the referring physician participates in a facility which has the patient's best interests in mind.

Disclose ownership to patients. The physician has an affirmative ethical obligation to disclose his ownership of a health facility to his patient, prior to admission or utilization. Upon request, a physician should give the patient a list of alternative facilities, if such are available, and inform the patient that they have the option to use one of the alternative facilities.

Comply with applicable law. Federal and state law prohibits incentive payments designed to induce physicians to admit patients to a hospital or other health care facility. Physicians may not lawfully or ethically accept such payments. Physicians may not ethically accept any payment, directly or indirectly, overtly or covertly, in cash or in kind, from a health care facility for services delivered by the facility.

Further, the Medical Practice Act, as interpreted by the Office of the Attorney General of Texas, may prohibit the direct division on a percentage basis of a physician's professional income with lay persons or to lay shareholders in a corporation or other business enterprise.

Duty to seek responsible change. Physicians recognize an ethical responsibility to seek changes in those requirements which are contrary to the best interests of the patient. The Board of Councilors believes that physicians have a right to seek changes in those laws which unduly restrict physician participation in health care facilities which primarily exist to serve the interest of the patient, do not result in exploitation of patients, do not involve fee splitting or other improper incentive payments, and do not present unresolvable conflicts of interest. It is in the best interest of the patient and community, not the physician, that such arrangements be allowed to continue.

HOSPITALISTS. Both the hospitalist and the primary care physician must have a commitment to reliable and effective communication with one another to ensure continuity of care between inpatient and outpatient settings.

The use of hospitalists should be a voluntary choice made by a primary care physician and the patient. Patients should be notified if their health care plan requires the use of a hospitalists, preferably at the time the patient enrolls in the plan. Patients also should be given a choice as to which hospitalists will be providing for their care.

HOSPITALS.

ADMISSION FEE. Use of the term "Admission fee" on a physician's bill is misleading because it implies charging a fee for the mechanics of obtaining the admission of a patient to a hospital, which is unethical. The charge is for taking the medical history, and physical examination. Use of terms such as "initial treatment, history, and examination" more clearly designate that all the services were professional.

EMERGENCY ROOM. When a patient seeking services at a hospital emergency room indicates he has a

private physician, that physician should be notified as soon as is practical that his patient is being treated in the emergency room.

MEDICAL STAFF APPOINTMENTS. The House of Delegates of the American Medical Association endorses the principle of a single standard with respect to staff appointments among all physicians having equivalent credentials in all hospital departments and services as a means of assuring maximum freedom of choice of physicians by patients, and of consultants by staff members, among all available and qualified doctors of medicine practicing in the hospital's community area. A "single standard" for appointment of all physicians should in no way preclude effective departmental organization and appropriate delegation of authorization and responsibility.

OPERATING ROOM TECHNICIANS. Any non-physician who assists a physician in a hospital setting should be subject to review by the Credentials Committee and any procedures performed should be in accordance with the law and other limitations imposed by the medical staff.

IMPAIRED DRIVERS. During the course of the physician-patient relationship, a physician may learn that the patient has a physical or mental impairment that might adversely affect the patient's ability to drive. If the physician believes that the patient has such an impairment, the physician should discuss the risks of driving with the patient, and, with the consent of the patient, the patient's family, if appropriate, and the means of reducing that risk.

In situations which the physician believes that the patient's physical or mental impairment poses an imminent threat to the safety of the patient or others, the physician should advise the patient to discontinue driving privileges. If the physician believes, however, that the patient will not follow his/her advise, it is desirable and ethically permissible that the physician notify the authorities. When advising the patient to discontinue driving privileges, the physician also should inform the patient that the physician will report him/her to the authorities as authorized by law if the physician believes that the patient will not follow the physician's advice.

IMPAIRED PHYSICIANS. It is unethical for a physician to practice medicine while under the influence of a controlled substance, alcohol, or other chemical agents which impair the ability to practice medicine.

INCENTIVE PAYMENTS.

INCENTIVE PAYMENTS -- HOSPITALS. Federal law prohibits incentive payments by a hospital designed to induce physicians to admit Medicare patients to the hospital. Physicians may not lawfully or ethically accept such payments. Physicians may not ethically accept any payment, directly or indirectly, overtly or covertly, in cash or in kind, from a hospital for services delivered by the hospital.

Physicians routinely maintain medical records in the course of their office and hospital practices. Timely completion of such charts is advisable from both the standpoints of liability protection and compliance with hospital medical staff bylaws. In addition, the completion of medical charts is traditionally regarded as part of the service rendered to the patient, and not a separate procedure for which payment is asked or expected.

The payment for completion of medical charts, from any source, is improper because it is an inducement to do that which good medical practice routinely requires of physicians, and may constitute an inducement to refer patients to a facility for reasons other than the quality of the services rendered in that facility."

INCENTIVES PAYMENTS -- THIRD PARTY PAYORS. It is the opinion of the Board of Councilors that the ethical obligation by a physician to provide quality medical care to a patient supersedes any financial incentive between the physician and a third party payor.

INSURANCE ISSUES.

MISREPRESENTATION AND PAYING FOR INSURANCE PREMIUMS. It is unethical for a physician to misrepresent a patient's symptoms or diagnosis in order to obtain authorization for a treatment that the physician believes is medically necessary or appropriate.

When conflicts arise regarding the medical necessity or appropriateness of a request for treatment, mechanisms should be in place to resolve the conflict in a timely fashion. If the physician believes that the mechanisms in place are inadequate, the physician should work to improve those mechanisms.

INTERNET PRESCRIBING. Although the development of telecommunications technology now makes it possible for physicians to prescribe medications by means of the Internet, such prescription writing may be unethical. The medium of the Internet itself imposes limitations on communications that are not present in a traditional office setting, or even in a telephone conversation. However, there may be situations in which Internet prescribing may be appropriate, e.g., when a prior long-standing physician-patient relationship exists between the physician or other physicians and the individual requesting the prescription or in emergency or short-term situations. If the individual seeking a prescription, has never been a patient of the physician, it is not ethically appropriate for the physician routinely to prescribe the requested medication without the benefit of a hands-on examination.

LABORATORIES. The practice of pathology is an integral part of the practice of medicine. A physician should not utilize the services of any laboratory, whether operated by a physician or a non-physician, unless he has utmost confidence in the quality of its services. He must always assume personal responsibility for the best interest of his patients. Medical judgment based upon inferior laboratory work is likewise inferior.

MANAGED CARE.

ETHICAL RESPONSIBILITIES OF PHYSICIANS IN MANAGED CARE PLANS.

1. Physicians must always place the best interests of their patients first. This is true regardless of the nature of the reimbursement system involved, whether it is managed care, indemnity insurance, or governmental entitlement. This is also true regardless of the type of setting in which care is provided, whether it is a health maintenance organization, a preferred provider organization or some other new type of practice entity, or a traditional practice setting. Consistent with this, physicians must advocate for any care they believe will materially benefit their patients.
2. Physicians should not be asked to participate in health care rationing decisions on an individual patient basis beyond the traditional cost/benefit judgments that are made as part of normal professional responsibilities. Broad cost/benefit judgments should only be made at a policy level with appropriate physician input.
3. Physicians should assist patients who wish to seek additional appropriate care outside the scope of managed care plan benefits when the physician believes that the care is in the patient's best interests.
4. Physicians should promote full disclosure to patients enrolled in managed care plans. This includes disclosure of treatment alternatives not provided as plan benefits.
5. Physicians should not participate in any plan that encourages or requires care at below minimum professional standards.
6. The Board of Councilors opposes gag clauses or confidentiality clauses in managed care contracts that prevent physicians from openly communicating with patients. Such clauses violate a physicians ethical duty to deal honestly with patients.
7. A physician should always remember that as a patient's advocate, the physician may have to appeal denials of care in a specific case. Both the physician and the health plan must place the needs of the patient ahead of their financial concerns. Consequently, a physician should not allow a health plan to interfere with that physician's ability to appeal denial of care that the physician believes is medically necessary.
8. Patients must be informed of any financial incentives that could affect the type and level of care the patient receives. This responsibility falls first on the health plan. Physicians must not be prohibited from discussing all circumstances that might affect the care their patients receive, whether it be treatment options available through the patient’s plan, or the financial mechanisms under which the physician is compensated.

MARIJUANA. Research in the therapeutic use of marijuana falls under the category of experimental medicine and as such the existing standards relating to experimental medicine should apply.

MARKETING OF HEALTH CARE SERVICES. The aggressive marketing of health care services by hospitals, Health Maintenance Organizations and similar third-party organizations has become a standard business practice. These marketing practices are intended to increase the organization's market share and may also help patients make informed health care decisions. Physicians may participate in such marketing plans if they find it advantageous, because they are generally free to choose with whom to associate and the environment in which to provide medical services. In some cases, though, these marketing practices may place physicians in uncomfortable ethical positions. The following statement is offered for the guidance of physicians who seek to maintain the highest level of ethical conduct in considering whether or not to become involved in the third party marketing of health care services.

1. Physicians are ethically and legally required to maintain the confidential nature of the physician-patient relationship, which under Texas law also includes the patient's identity. If a marketing plan calls for physicians to provide listings of patients to third parties for marketing or promotional activities, then the physician should not release patients' names unless the patients have first consented to the release in writing. Furthermore, physicians have an obligation to ensure that no other confidential patient information is released without proper authorization, for example, information regarding patients with a particular diagnosis or requiring common treatment regimens which might be targeted in marketing activities.
2. Physicians are ethically required to base referrals on the skill and quality of the physician or other provider to whom the patient has been referred, for to do otherwise violates the requirement to deal honestly with patients and colleagues. Legal liability may also result. Physicians should not become involved in health care marketing plans which place the physician in the position of referring, recommending, or endorsing, (or appearing to do so,) particular providers or services that the physician is not satisfied are warranted on the basis of skill or quality. This may be a particular problem where the marketing plan calls for referring or recommending patients to a broad range of other services or providers with whom the physician may be unfamiliar.
3. If a physician receives compensation from a health care service marketing plan in exchange for enrolling patients in the plan, the physician has an affirmative ethical obligation to disclose to the patient that he or she will receive compensation if the patient chooses to use the marketing plan as a result of the physician's efforts. This holds true even if the promotional activities are carried out by the physician's employees. Physicians may prohibit their employees from marketing health care services with which the physician does not wish to become involved.
4. If a physician pays a fee to a health care service marketing plan in exchange for marketing that physician's services, the physician should be assured that the fee paid is for the marketing services themselves, and not for patient referrals. A physician should not become involved with a health care service's marketing plan which requires payment of a fee that increases with the number of patients who elect to use the physician's services as a result of marketing services.
5. Physicians should not participate in health care service marketing plans which use false, misleading or deceptive advertising practices, or allow a marketing plan to use a physician's name, likeness or other information about the physician in a materially misleading fashion.

MEDICAL CREDIT CARDS. Bank credit cards provide some patients with an option of paying for a physician's services. Physicians should not receive additional income or alter their fee schedules because of a decision to accept patients' bank credit cards.

MEDICAL DIRECTORS. Simply because a physician is not providing direct patient care does not mean that the physician is not practicing medicine or obligated to adhere to the principles of medical ethics. Whenever physicians employ professional knowledge and values gained through medical training and practice, and in so doing affect individual or group patient care, they are functioning within the professional sphere of physicians and must uphold ethical obligations. This is true not only if the physician is making determinations of medical necessity or coverage, but also if the physician is involved in developing a health plan’s general policies that affect patient care, e.g., utilization guidelines.

MEDICAL EXPERT TESTIMONY. A physician who testifies as a medical expert must only provide

evidence and opinions that are reliable and helpful to the trier of fact in a legal dispute. To that end, a physician should prepare and become familiar with relevant facts and scientific literature. It is unethical for a physician to provide expert medical testimony in a legal proceeding which has little or no basis in scientific fact or is merely subjective belief or unsupported speculation.

A physician testifying as an expert must have recent and substantive experience in the medical field at issue in the legal dispute. It is unethical for a physician to testify upon matters when he or she is not familiar with or experienced in present accepted practices.

A physician testifying as an expert must first review prior and current concepts related to the standard(s) of care upon which the physician will testify.

A physician testifying as an expert must strive to testify as to the standard of care in the community in question, not the standard in another part of Texas, the United States, or the world.

A physician testifying as an expert must clearly indicate to the legal decision maker(s) which part of his or her testimony is personal opinion and not generally accepted by the physician community or that is not common practice.

In medical professional liability litigation a physician's medical expert testimony must not be tailored to fit legal strategies or theories.

It is unethical for a physician to fabricate a medical expert opinion for the purpose of attaining a particular outcome in a liability lawsuit.

Independence in medical professional judgment is as essential for reliable testimony as it is for the delivery of appropriate health care. It is unethical for a physician to accept or agree to accept fees for testifying as a medical expert contingent upon a particular outcome in a legal dispute. **(January 2003, rev. April 2003)**

MEDICAL FUTILITY. If a patient is involved in end-of-life circumstances, and the patient or the surrogate requests life-sustaining treatment that the physician does not believe will medically benefit the patient, the physician should consult an ethics committee, where available. In some circumstances, even if the ethics committee and the physician agree that the requested care is futile, state law dictates that the physician must provide the care for ten days while attempting to locate another physician or other institution that will provide the requested treatment. However a physician is not ethically required to accept the transfer of such a patient.

MEDICAL NECESSITY. The determination of medical necessity is the practice of medicine; it is not a benefit determination. Whether or not a proposed treatment is medically necessary should be decided in a manner consistent with generally accepted standards of medical practice that a prudent physician would provide to a patient for the purposes of preventing, diagnosing or treating an illness, injury, disease or its symptoms. This is true even if the physician making the medical necessity determination is making those decisions on behalf of a managed care organization. That physician must not permit financial mechanisms to interfere with his/her determination as to whether a treatment is medically necessary. Although the physician may take cost considerations into account, the physician may not refuse to approve the medical necessity of a treatment simply based on cost, and must approve the treatment if it is clearly more therapeutically effective than other treatment options that may be covered under the plan, even if those treatment options are less expensive than their more costly counterpart.

MEDICAL STUDENTS -- SUPPORT GROUPS. TMA encourages development of alternative methods for dealing with the problems of student-physician mental health in medical school, such as introduction to the concepts of physician impairment at orientation; ongoing support groups consisting of students and house staff in various stages of their education; journal clubs; fraternities; support of the concepts of physical and mental well being by heads of departments, as well as other faculty members; and/or the opportunity for interested students and house staff to work with students who are having difficulty. TMA believes that these alternatives should be available to students at the earliest possible point in their medical education.

MIDWIFERY. TMA believes registered nurse midwife practitioners working in association with physicians can provide quality care for expectant mothers. However, TMA opposes legislative and regulatory efforts by the State which encourage expansion of lay midwifery.

NURSE ANESTHETISTS. Anesthesiologists may ethically participate in the training of nurse anesthetists and may provide consultation for patients receiving nurse-administered anesthesia when such consultation is requested by the operating surgeon.

ORGAN DONORS.

ANENCEPHALIC INFANTS AS ORGAN DONORS. Physicians may provide anencephalic infants with ventilator assistance and other medical therapies that are necessary to sustain organ perfusion and viability until such time as a determination of death can be made in accordance with accepted medical standards and relevant law. Retrieval and transplantation of the organs of anencephalic infants are ethically permissible only after a determination of death is made, and only in accordance with the AMA Council on Ethical and Judicial Affairs' guidelines for the transplantation or organs.

ON-CALL PHYSICIANS. If the on-call physician provides care to the patient, such provision creates a physician-patient relationship. Because of the creation of the physician-patient relationship, the physician should provide or arrange follow up care to the patient. The physician is not, however, obligated to treat the patient for a condition that is unrelated to the condition for which the physician initially treated the patient in the emergency room.

PATIENT RECORDS.

AUTHORIZATION FOR RELEASE. Physicians face both an ethical and a legal responsibility to safeguard patient communications and information in patients' medical records. Such information is confidential and privileged and may not be released except under circumstances outlined in the Medical Practice Act of Texas. Patient authorizations for release of confidential information should be in writing, signed by the patient or someone legally authorized to act on his/her behalf, and should specify the following: (1) the records which are to be covered by the release, (2) the reasons or purposes for the release, and (3) the person to whom the information is to be released.

Reporting of cases to cancer and other registries is not unethical if done in conformity with the Medical Practice Act.

DELINQUENT ACCOUNTS. It is unethical for a physician to refuse or to delay improperly in responding to a valid request for transfer of a former patient's medical records because of an unpaid bill. The physician's first responsibility is the care and welfare of the patient. Other alternatives are available for the collection of fees.

SALE OF. It is both legal and ethical to sell a medical practice and patient records so long as the sale of records contains provisions to insure that the purchaser agrees to make records of any patients treated by the selling physician available to subsequent physicians, or to other persons the patients designate. All active patients should be notified that their physician is selling his/her practice to another physician who will retain custody of their records, or forward them to other physicians upon proper authorization. Because Texas law contains no applicable exceptions to patient confidentiality in practice sale situations which allow medical records or other confidential material to be disclosed to non-physicians without patient consent, medical records are not considered "assets" of a physician's medical practice that can be sold to a non-physician. Thus, to be ethical the sale must be consummated with a physician, duly licensed to practice, and in good standing. Where non-physicians are or will be involved in the management of a medical practice or other organization to which medical records will be sold or transferred, physicians must take appropriate action to ensure that such non-physicians: (a) will not use or disclose the information for any other purposes; and (b) will take appropriate steps to protect the information.

PAYMENT FOR COMPLETION OF MEDICAL CHARTS. Physicians routinely maintain medical records in the course of their office and hospital practices. Timely completion of such charts is advisable from both the standpoints of liability protection and compliance with hospital medical staff bylaws. In

addition, the completion of medical charts is traditionally regarded as part of the service rendered to the patient, and not a separate procedure for which payment is asked or expected.

The payment for completion of medical charts, from any source, is improper because it is an inducement to do that which good medical practice routinely requires of physicians, and may constitute an inducement to refer patients to a facility for reasons other than the quality of the services rendered in that facility.

PAYOR INTERFERENCE WITH CONFIDENTIALITY. Physicians have both ethical and legal obligations to safeguard the confidentiality of patient information within the bounds of the law. Third party payors, including government agencies involved in the payment of fees for medical care, have the right to receive accurate information in order to pay claims. However, physicians should not release confidential information to payors in excess of the need to pay claims without the patient's written consent. Under no circumstances should a physician allow representatives of third party payors or government agencies to be present in any capacity at a time and place where patients are examined or treated. This is a clear violation of the confidentiality of the physician-patient relationship. Such presence is inherently coercive because it may cause the patient not to make a full disclosure of information to the physician in order that the physician may most effectively provide needed services. Such problems cannot be cured by a purported consent executed by the patient, as such consent would not be free and voluntary.

PATIENT'S RIGHTS UPON PHYSICIAN'S DEPARTURE FROM A GROUP. When a physician leaves a group practice, and, if requested by a patient of that physician, the group practice must inform that physician's patient of the departing physician's new address, and that copies of the patient's medical records may be forwarded to the departing physician's new practice. It is unethical to withhold such information upon request of a patient. Additionally, the fact that a physician leaves a group practice should not cause any patient to be neglected or abandoned. It is unethical to interfere with the relationship between the departing physician and his or her patients by withholding information, even when there are other physicians remaining in the group who are qualified to render the necessary care.

PATIENT TRANSFERS. Physicians should not refer patients to other physicians or to any other provider of health care services unless they are confident that the needed services will be performed competently and in accordance with accepted scientific standards and legal requirements. Even in an emergency, the referring physician should make every attempt to ascertain the identity and capabilities of the physician who is being asked to assume responsibility for the patient's care. The attending physician who refers simply to a hospital or to another institution, no matter what its reputation, is abrogating his or her professional responsibility to the patient. If a hospital encourages such referral patterns by contacting physicians in distant communities and offering what may be high-quality medical transportation services, the hospital's medical staff should point out the ethical issues involved.

PAYING FOR INSURANCE PREMIUMS. It is ethical for a physician to pay a patient's insurance premiums provided the physician does not receive a direct or indirect benefit. Thus, a physician should not charge or bill the patient or his insurance company for the physician's services to that patient. Such payments should only be made in compliance with state and federal law and where true hardship exists.

PHYSICIAN ASSISTANTS. Rules of the Texas State Board of Medical Examiners indicate that services provided by physician assistants are considered to be part of the global services provided by the supervising physician, and there shall be no separate billing for the services rendered by a physician assistant. The physician must, of course, retain overall responsibility for direction of patient care and for maintenance of the physician-patient relationship.

PHYSICIAN HEALTH AND REHABILITATION. The Texas Medical Association supports the establishment of comprehensive treatment programs, as well as training and rehabilitation, for impaired physicians. Such rehabilitation programs should include continuing medical education

opportunities through medical schools, as well as supervised employment whenever possible for physicians undergoing treatment, or for those physicians whose licenses have been restricted.

PHYSICIAN NOTIFICATION. When a patient threatens to inflict serious bodily harm to another person or to himself or herself, and there is a reasonable probability that the patient may carry out the threat, the physician should take reasonable precautions for protection of the intended victim, including notification of law enforcement authorities.

Communicable diseases, gunshot wounds, and knife wounds should be reported as required by applicable statutes and ordinances.

When the physician-patient relationship is being exploited for the surreptitious procurement of controlled drugs for non-therapeutic use, the physician may report the patient to law enforcement authorities as allowed by applicable statutes or ordinances.

PLACEBO SURGERIES. Placebo surgeries raise sufficient ethical concerns and should not be performed unless sufficient patient protections are in place. Obtaining informed consent from the research subjects involved may allay some of these ethical concerns. However, physicians involved in placebo surgeries must be sensitive to the possibility that the patients may be consenting to be research subjects because no treatment other than the one being tested holds out any promise of efficacy. Physicians must be certain that potential research subjects are fully aware that they may not be receiving the treatment being investigated, and that there is no guarantee that the treatment will be successful, or that they will be able to obtain the treatment at a later time.

PRESCRIPTIONS-ELECTRONIC. Patients have the right to have a prescription filled wherever they wish and physicians should respect the patient's freedom of choice. The use of electronic prescription programs that require prescriptions be dispensed from a particular pharmacy while also refusing to provide a paper prescription to permit the patient to choose where to fill the prescription is unethical. Further, physicians should avoid situations which inappropriately limit the patient's medication options. **(Adopted September 2003)**

PRESCRIPTION PADS. Physicians may not use prescription order forms which are furnished to them containing a preprinted order for a drug product by brand name, generic name, or manufacturer. Physicians themselves may secure prescription pads preprinted with whatever information they require for efficient treatment of their patients, although the apparent endorsement of a particular pharmacy may mislead or confuse patients. It may be helpful to pharmacists for physicians to use pads with their names printed thereon.

PRINCIPLES OF MEDICAL ETHICS, AMA. The Principles of Medical Ethics of the American Medical Association shall govern the conduct of members of the Texas Medical Association in their relationships with each other and the public.

PROFESSIONAL COURTESY. The custom of professional courtesy embodies the ancient tradition of fraternalism among physicians in the art which they share, and their mutual concern to apply their learning for the benefit of one another as well as their patients. Professional courtesy is a noble tradition which is adaptable to the changing scene of medical practice.

Professional courtesy is not a rule of conduct that is to be enforced under threat of penalty of any kind. It is the individual responsibility of the physician to determine for himself and within his own conscience to whom and the extent to which he shall allow a discount from his usual and customary fees for the professional services he renders, and to whom he shall render such services without charge as professional courtesy.

The following guidelines are offered as suggestions to aid physicians in resolving questions related to professional courtesy.

1. Where professional courtesy is offered by a physician but the recipient of services insists upon payment, the physician need not be embarrassed to accept a fee for his services.

2. Professional courtesy is a tradition that applies solely to the relationship that exists among physicians. If a physician or his or her dependents have insurance providing benefits for medical or surgical care, a physician who renders such service may accept the insurance benefits without violating the traditional ethical practice of physicians caring for the medical needs of colleagues and their dependents without charge.
3. In the situation where a physician is called upon to render services to other physicians or their immediate families with such frequency as to involve a significant proportion of his professional time, or in cases of long-term extended treatment, fees may be charged on an adjusted basis so as not to impose an unreasonable burden upon the physician rendering services.
4. Professional courtesy should always be extended without qualification to the physician in financial hardship, and members of his or her immediate family who are dependent upon him.
5. In the case of treatment of an impaired physician where payment for services is desirable to establish recognition of the patient/physician relationship between the ill physician and his or her treating physician, it is felt that the treating physician should be paid as any other regular physician for all professional, medical, or therapeutic services he or she renders.

PROFESSIONAL RELATIONSHIPS. Physicians should refrain in listings of professional employees from including information which is false, misleading, or deceptive. Non-physician professional employees may be identified by name and profession at the site of employment and by means of any communication through which the patient may benefit.

RELATION BETWEEN LAW AND ETHICS. Ethical values and legal principles are usually closely related, but ethical obligations typically exceed legal duties. In some cases, a law is unjust because it mandates unethical conduct. In other cases, a law is unjust because it prohibits ethical conduct. In general, when physicians believe a law is unjust, they should work to change the law.

The fact that a physician charged with allegedly illegal conduct is acquitted or exonerated in civil or criminal proceedings does not necessarily mean that the physician acted ethically.

SALE OF HEALTH RELATED PRODUCTS FROM PHYSICIANS' OFFICES. The for-profit sale of health-related products by a physician can create a conflict of interest for the physician. The conflict of interest exists because the physician has a financial interest in selling the products. Concern about the conflict of interest is heightened because of the unique nature of the physician-patient relationship. The basis of the physician-patient relationship is trust. The for-profit sale of health-related products risks demeaning the relationship and the professional practice of medicine.

SEXUAL MISCONDUCT. Sexual contact that occurs concurrent with the patient-physician relationship constitutes sexual misconduct and is unethical. Sexual or romantic relationships with current or former patients or key third parties are unethical if the physician uses or exploits trust, knowledge, emotions, or influence derived from the professional relationship. Key third parties include, but are not limited to, spouses or partners, parents, guardians, or proxies.

STUDENT LOAN DEFAULTS. A physician member's default on a student loan is no different from the physician's failure to fulfill any other legal, contractual obligation. Since similar conduct in the physician's private life does not subject him or her to disciplinary sanctions under the TMA Bylaws, neither should default on a TMA student loan. The Association retains the right to pursue legal remedies.

SUICIDE. Physicians have ethical duties to sustain life and relieve suffering. The performance of these duties may cause one duty to conflict with another in the case of terminally ill patients. A physician may ethically cease or omit treatment to permit a terminally ill patient whose death is imminent, to die. However, he should not intentionally cause death.

Physicians also have an ethical duty to conform their conduct to the requirements of law. Assisting suicide is a criminal offense. It is unethical for a physician to intentionally aid or assist any patient, directly or indirectly, in taking the patient's own life, regardless of the patient's mental state or severity of illness.

It is not unethical for a physician to prescribe medications to alleviate a terminally ill patient's pain even though a side-effect of the drug could be to compromise respiration and circulation, if the physician's intention is to alleviate pain and not to hasten the patient's death.

SURROGACY. Physicians may be called upon to care for women who have contracted to carry a fetus for another couple (the "contracting couple") pursuant to a legitimate adoption of the resulting child. These arrangements are termed "contractual surrogacy arrangements" and fall into two general categories: (1) a woman who has been impregnated by donor sperm from a man not her husband, and (2) a woman who has been implanted with a fertilized ovum provided by another couple. Although contractual surrogacy arrangements are, at this time, unusual, they raise questions about the physician's ethical duties.

The physician's primary patients are the woman who will bear the child (the "birth mother") and the unborn child. The physician's duty is to provide competent medical care for these patients.

The physician's duty to these patients is not to be influenced by consideration of who may ultimately be regarded as being the child's "legal" parents. Good medical practice should no more be affected by this issue than it would in the case of a woman who plans to give up her natural child for adoption.

When all parties to the contractual surrogacy arrangement are patients of the treating physician (such as when the couple is treated for infertility), the physician may reveal information about the health status of the birth mother and unborn child to the contracting couple. This is because the birth mother, by her assent to the contractual surrogacy arrangement, has implied that she agrees to a release of confidential information about herself and the unborn child to the contracting couple, limited to information relevant to health care decisions the contracting couple might have to make or be consulted about before or during the pregnancy. The physician should not reveal other confidential information about the birth mother to the contracting couple without the birth mother's informed consent.

However, if the physician treats a pregnant woman and is not aware that a contractual surrogacy arrangement is in effect, he or she should not reveal confidential information about the patient to anyone else without the patient's informed consent.

A physician should not allow anyone, including the contracting couple, to dictate the quality or extent of medical care rendered to the patients. This is true even in cases where the contracting couple are agreed to be responsible for payment of fees. The physician may consider information provided by the contracting couple when that information (e.g., a history of genetic disorders) is relevant to decisions about patient care.

If the physician is unaware of the contractual surrogacy arrangement and delivers the child, the birth certificate should be prepared based on the information known at the time of delivery.

A physician should not, under any circumstances, knowingly participate in a scheme in which a child is bought or sold in violation of the laws of this or any other state of the United States.

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900 SERVICE TELEPHONE NUMBERS. The Board of Councilors endorsed the American Medical Association's opinion on 900-service telephone numbers which encourages efforts to disseminate medical information through various media, including for-profit telephone services. Physicians using 900-phone service should not prescribe medications nor receive compensation based on the amount of revenue generated by the calls they handle and should insulate themselves from conflicts.

TERMINATION OF THE PATIENT-PHYSICIAN RELATIONSHIP

The patient-physician relationship is wholly voluntary in nature and therefore may be terminated by either party. However, physicians have an ethical obligation to support continuity of care for their patients. Thus, it is unethical for a physician to terminate the patient-physician relationship without first providing reasonable notice under existing circumstances of the physician’s intent to terminate the professional relationship. To terminate the patient-physician relationship without such notice may result in civil liability for abandonment. **(Apr. 2003)**

TREATMENT OF FAMILY MEMBERS AND FRIENDS.

One of the physician's primary duties is to alleviate suffering. Thus, it is ethical to treat family and friends in immediate need. In those circumstances medical records may not be relevant. The Board of Councilors cautions a physician treating his or her family or friends because of the potentially hazardous medical consequences. **(Modified May 2006)**

UNSOLICITED MEDICAL _SCREENING TEST RESULTS. Patients are best served when tests are ordered by a physician and the physician directs the course of a patient's diagnostic and therapeutic care. Physicians who provide direct-to-consumer diagnostic tests should be mindful of this Board's opinions entitled HEALTH FACILITY OWNERSHIP, INCENTIVE PAYMENTS AND CONFLICTS OF INTEREST.

A physician might receive unsolicited medical test results on behalf of persons with whom they have not established a physician-patient relationship, who have given the physician's name in order to receive the medical screening test. In this event, physicians may return the results to the medical screening agency. In no event does receiving unsolicited medical screening test results alone establish a physician-patient relationship. **(Modified Feb. 2005).**

_UTILIZATION REVIEW. The physician who performs prospective and/or concurrent utilization review is obligated to review the request for treatment with the same standard of care as would be required by the profession in the community in which the patient is being treated.

_WITHHOLDING OR WITHDRAWING LIFE -- PROLONGING MEDICAL TREATMENT. The social commitment of the physician is to sustain life and relieve suffering. Where the performance of one duty conflicts with the other, the choice of the patient, or his family or legal representative if the patient is incompetent to act in his own behalf, should prevail. In the absence of the patient's choice or an authorized proxy, the physician must act in the best interest of the patient.

For humane reasons, with informed consent, a physician may do what is medically necessary to alleviate severe pain, or cease or omit treatment to permit a terminally ill patient whose death is imminent to die. However, he should not intentionally cause death. In deciding whether the administration of potentially life-prolonging medical treatment is in the best interest of the patient who is incompetent to act in his own behalf, the physician should determine what the possibility is for extending life under humane and comfortable conditions and what are the prior expressed wishes of the patient and attitudes of the family or those who have responsibility for the custody of the patient.

Even if death is not imminent but a patient's coma is beyond doubt irreversible and there are adequate safeguards to confirm the accuracy of the diagnosis and with the concurrence of those who have responsibility for the care of the patient, it is not unethical to discontinue all means of life-prolonging medical treatment.

Life-prolonging medical treatment includes medication and artificially or technologically supplied respiration, nutrition or hydration. In treating a terminally ill or irreversibly comatose patient, the physician should determine whether the benefits of treatment outweigh its burdens. At all times, the dignity of the patient should be maintained.

WITHHOLDING OR WITHDRAWING LIFE -- PROLONGING MEDICAL TREATMENT -- PATIENT'S _PREFERENCES. A competent, adult patient may, in advance, formulate and provide a valid consent to the withholding or withdrawal of life-support systems in the event that injury or illness renders that individual incompetent to make such a decision. The preference of the individual should prevail when determining whether extraordinary life-prolonging measures should be undertaken in the event of terminal illness. Unless it is clearly established that the patient is terminally ill or irreversibly comatose, a physician should not be deterred from appropriately aggressive treatment of a patient.

_MEMBERSHIP ISSUES

MEMBERSHIP _QUALIFICATIONS. A physician shall deal honestly with patients and colleagues, and

strive to expose those physicians deficient in character or competence, or who engage in fraud or deception.

A licensed and qualified physician should only be denied membership or continued membership in a county medical society for a violation of the TMA or county medical society constitution and bylaws, a violation of the Principles of Medical Ethics, criminal conduct, or unprofessional conduct likely to deceive, defraud, or injure the public. A physician should not be denied membership or continued membership solely because of an affiliation with a business, religious, political, or professional entity.

It is recommended that the basic principles of a fair and objective hearing be accorded to the physician whose professional conduct is being reviewed. The fundamental aspects of a fair hearing are: a listing of specific charges, adequate notice of the right to a hearing, the opportunity to be represented by a person of the physician's choice, the opportunity to be present and to rebut the evidence, and the opportunity to present a defense. All proceedings should be conducted in accordance with the policies, rules and opinions as established by the Association.

These principles of fair play apply whenever physicians sit in judgment of physicians and whenever that judgment affects a physician's reputation, professional status or membership in a county medical society.

MEMBERSHIP AFTER _EXPULSION. A county medical society should furnish an application form to all physicians who evidence a desire to join organized medicine. However, a county medical society is not obligated to furnish an application form to a physician who has been previously expelled from membership by the society for valid reasons set forth in the TMA Constitution and Bylaws. Expulsion from membership, when it becomes final, represents a valid legal action of the county medical society that the society is not obligated to ignore or overturn.

FAILURE TO HONOR _SERVICE OBLIGATIONS. A physician who fails to fulfill a contractual service obligation for no justifiable reason in return for funding for medical education expenses acts unethically because it: (1) violates principle II of the AMA principles of Medial Ethics, (2) violates Principle VII of the AMA Principles of Medical Ethics, and (3) violates TMA Bylaw 1.11 as unprofessional conduct likely to deceive, defraud or injure the public. A county medical society may consider such failure in considering membership or discipline.

_DISCIPLINE BY A COUNTY MEDICAL SOCIETY. When a member has been disciplined by a county medical society (such as expulsion), but has not exhausted all appeal rights, all rights and privileges of association membership still apply. This includes the right to file a complaint against another member. A number of possible situations may arise in this regard.

1. When the substance of the complaint is unrelated to matters involved in the case which resulted in the member's discipline, the Board of Censors should process that complaint according to the Hearings Procedures Manual.

2. When the substance of the complaint directly relates to matters involved in the case which resulted in the member's discipline, a county medical society has discretion in determining whether or not to investigate such a complaint.

"Complaints directly related" to matters involved in the case which resulted in discipline may include, but are not limited to: 1) any charge relating to the conduct of an investigation or hearing that could have been made in the form of an objection before the Executive Board but were not, 2) attacks on the credibility of a member who testified against the disciplined member at an investigative committee meeting, testified at a hearing or submitted a written report used in the investigation or hearing, or 3) charges of bias or direct economic competition with the disciplined physician.

When a society, in the exercise of such discretion, determines that it will investigate such a complaint, the Board of Censors should process that complaint according to the Hearings Procedures Manual.

When a society, in the exercise of such discretion, determines that it will not investigate such a complaint, that action is not subject to appeal.

3. When the substance of the complaint does not appear to relate directly to matters involved in the case resulting in discipline, the Board of Censors should process that complaint according the to Hearings Procedures Manual. If the investigation discloses that the complaint has direct a relation to the case resulting in discipline, the Board of Censors shall determines whether or not to proceed. If the Board of Censors determines that, due to the facts of the case resulting in discipline it cannot be objective, it may ask the society's Executive Board to refer the matter to the Board of Councilors for disposition.

In any event, the integrity and confidentiality of the disciplinary process must be preserved. It is important that disciplinary matters reach a point of finality, and a disciplined member should not be allowed to extend the process by the filing of frivolous complaints against those who participated in the disciplinary process. It is also important that the disciplinary process not be subverted for reasons of bias, personal gain or other improper motive. A society should be sensitive to well-founded complaints of this nature and give them due consideration.

PROCEDURE WHEN RIGHT TO HEARING WAIVED. If a county medical society member, who has received a Notice of Proposed Disciplinary Sanction as provided by the TMA Hearings Procedures Manual, fails to request a hearing before the applicable Executive Board within the prescribed time limit, the disciplinary sanction recommended by the Board of Censors shall become effective, without the necessity of further action by the applicable Executive Board, on the 31st day after the member received the Notice of Proposed Disciplinary Sanction.

DISCIPLINE -- NATIONAL PRACTITIONER DATA BANK REPORTING OBLIGATIONS. When a physician member loses his or her Texas medical license, that member no longer posses the basic qualification for membership as specified in the TMA Constitution: a valid Texas medical license. When that occurs, TMA may revoke the membership of such physician without the necessity of directing the appropriate county medical society to begin disciplinary action against that member, or reporting such action to the National Practitioner Data Bank. Such action is taken, not on the basis of the reasons which the Texas State Board of Medical Examiners had to revoke or cancel the license, but because the basic eligibility requirement for membership is no longer met. Similarly, when a member fails to pay membership dues and is dropped from TMA membership rolls for nonpayment, no disciplinary action is commenced, nor does reporting occur. Such actions on the part of TMA are purely administrative in nature and do not constitute formal peer review actions which invoke the due process requirements of the Hearings Procedures Manual.

If a society is uncertain as to whether it should report a specific action to the National Practitioner Data Bank, the TMA Office of General Counsel should be consulted.

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