

## EDITOR'S PAGE

# Issues and Ethics of the Hiring of Cardiothoracic Surgeons by Cardiology Practices

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At the March meeting of the American College of Cardiology (ACC) Ethics Committee, Dr. Richard G. Sanderson presented a position paper from the Society of Thoracic Surgeons (STS) on the above topic. Society members had ethical and legal concerns about the invitations by large groups of cardiologists for cardiac surgeons to join their practice, many times under the expressed or implied threat of withholding surgical referrals if the invitations were not accepted. Some of the following represent excerpts from that paper and presentation. This information was deemed by the Ethics Committee to have direct and important relevance for all our members.

“There is a growing number of employment arrangements and concomitantly, a growing number of reimbursement arrangements for medical practitioners, including surgeons. There has been a shift away from independent private practice, where a surgeon is essentially self-employed, to working within a group, often as a member of a multispecialty group. In academic university practice, a surgeon is often a full-time salaried member of a large group practice.

For a cardiac surgeon, being employed by a group of cardiologists is not necessarily any different from being employed by a group of surgeons or by a mixed group of practitioners. Groups of cardiac surgeons sometimes hire intensivists to help care for post-op patients, or transplant cardiologists to participate in the care of heart transplant patients. At issue is the question of intent; if the intent is to provide excellent medical care, the practice is laudable. If the intent is to subjugate medical decision making, then the practice is unethical.

This issue may be complicated further by the growing practice of ‘multidisciplinary’ care, which is in vogue for the treatment of oncologic problems by surgeons and is a growing phenomenon in the evolution of ‘Heart Centers.’ Once again, the question of intent is crucial. Is the movement to multidisciplinary care altruistic and in the best interest of the patient, or is it a marketing gimmick to lure unsuspecting patients to a particular provider? Does the practice of referral to other members of the multidisciplinary team result in a conflict of interest because it is self-serving for the group? The answer is ‘yes’ only if the referral is not indicated, or if the practitioner truly believes the patient

would be best suited by treatment by another practitioner outside of the group. Most multidisciplinary clinics bring together specialists who have expressed the desire to work together, presumably out of mutual respect for each other’s knowledge and skills.

The issue of requesting money in exchange for a commitment to refer patients is clearly fee splitting. In the current context, it qualifies as a form of professional extortion. The ACC held a conference in Bethesda in 1997 to outline College policies regarding conflict of interest and ethics. The practice of fee splitting contravenes principles in this document, is identified as unethical in the American Medical Association Code of Medical Ethics, and was one of the cornerstones for the formation of the American College of Surgeons (ACS). Prohibition of the practice is part of the ACS Statement on Principles. The practice is illegal and could result in criminal charges being brought against both parties. Clearly, the intent of fee splitting has nothing to do with providing quality care for patients.

Cardiac surgeons may be more vulnerable to this practice of professional extortion than any other sub-specialty in surgery because of the logistics of referral of patients with cardiac disease. Frequently, a large number of patients emanate from one cathing cardiologist, and it is conceivable that two or three such cardiologists can keep one cardiac surgeon busy. Practitioners in most other disciplines of surgery are not so beholden to two or three individuals for their livelihood.

Although the direct requesting of money in exchange for a promise of referrals is an obvious example of illegal fee splitting, more subtle examples exist that might be subject to scrutiny under anti-kickback statutes, in which giving anything “of value” in consideration for referrals is prohibited. Relinquishing one’s independence for ongoing referrals could be considered to be “of value” when the employer cardiologists have the surgeons’ undivided attention and loyalty, usually excluding surgical referrals from competing cardiologists. More specifically, these statutes might be applied if the surgeons are compensated at less than fair market value (i.e., below market salary, discounted fee schedule, or an offer to join the practice on terms that are less favorable than those that apply to the cardiologists). Intra-practice techniques, such as disproportionately in-

creasing administrative expenses and overhead allocations to the surgeons or excessive redistributing income to the cardiologist employers, could also trigger anti-kickback scrutiny.

At the core of the ethical concerns about these hiring practices is the possibility/probability of producing an actual conflict of interest in the surgeon's obligation to act as a fiduciary for the patient's best interests. If surgeons fear for their own employment and financial security and thereby defer to the cardiologist employer's opinion and desires, financial considerations are clearly in conflict with the surgeon's primary obligations to their patients.

Summary: Surgeons considering joining a cardiology practice should first ensure that they are compatible with the group's views of high-quality patient care and the role of surgical intervention. Contracts should be carefully evaluated to make sure that:

1. The surgeons' independent judgments of what is best for their patients are not compromised by requirements of

inappropriate oversight or subordination to group decision making.

2. Financial arrangements do not encourage overutilization or underutilization of surgical services.
3. There are no contract clauses that prevent the surgeons from:
  - a. acting in the patients' best interest at all times;
  - b. discussing any medical or financial issues with the patients;
  - c. disclosing financial or other incentives or disincentives with the patients without jeopardizing the physician-patient relationship."

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## REFERENCE

1. Parmley WW, Passmani ER. 29th Bethesda Conference. Ethics in Cardiovascular Medicine. *J Am Coll Cardiol* 1998;31:917-49.