Nephrologists’ Professional Ethics in Dialysis Practices

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Summary
Although the number of incidents is unknown, professional quality-oriented renal organizations have become aware of an increased number of complaints regarding nephrologists who approach patients with the purpose of influencing patients to change nephrologists or dialysis facilities (hereinafter referred to as patient solicitation). This development prompted the Forum of ESRD Networks and the Renal Physicians Association to publish a policy statement on professionalism and ethics in medical practice as these concepts relate to patient solicitation. Also common but not new is the practice of nephrologists trying to recruit their own patients to a new dialysis unit in which they have a financial interest. This paper presents two illustrative cases and provides an ethical framework for analyzing patient solicitation and physician conflict of interest. This work concludes that, in the absence of objective data that medical treatment is better elsewhere, nephrologists who attempt to influence patients to change nephrologists or dialysis facilities fall short of accepted ethical standards pertaining to professional conduct, particularly with regard to the physician–patient relationship, informed consent, continuity of care, and conflict of interest.


Introduction
There has been a recent increase in complaints to professional quality-oriented renal organizations regarding nephrologists who approach patients under the treatment of other nephrologists with the purpose of influencing patients to change nephrologists or dialysis facilities. This development prompted the Forum of ESRD Networks (Forum) and the Renal Physicians Association (RPA) to publish a policy statement on professionalism and ethics in medical practice as these concepts relate to patient solicitation (1). There is also the reported problem of nephrologists who try to recruit their own patients to transfer their care to a new dialysis unit in which their nephrologist has a financial interest. This paper will focus on the professional issues raised by patient solicitation and physicians’ conflict of interest, and it will present ethical principles for evaluating them. Two cases will be analyzed according to the ethical framework presented in this paper.

Case 1: Dialysis Patient Solicitation
Nephrology groups A and B have both been following dialysis patients at Best Dialysis Center (BDC). Recently, group A opened a new facility nearby: Great Kidney Center (GKC). Although several BDC patients transferred for convenience of location, some patients left despite living closer to BDC. On inquiry, group B nephrologists discovered that, when their patients were hospitalized under the care of group A nephrologists at hospitals where group B physicians did not see patients, the patients were often allegedly told that GKC offered better care than BDC. Some patients reported being called at home by group A nephrologists or their clinical staff with the same message. There are no objective quality measures to support the claims that group A nephrologists or GKC provide better care than group B nephrologists or BDC.

Case 2: Nephrologist Financial Conflict of Interest
Nephrologist A enters a limited partnership that opens a new dialysis unit in a town in which there is already a well established unit. Nephrologist A will be the medical director of this unit, and he or she recommends to dialysis patients under his/her care that they transfer to this new facility, because the care will be better there. There are no objective data to support the claim of superior quality for the new dialysis unit.

Professions and Their Ethics
The practice of medicine in general and nephrology in particular is a profession. In 1927, Harvard physician Francis Peabody famously wrote that “medicine is not a trade to be learned but a profession to be entered” (2). A profession is a group of persons who have expertise as a result of mastering a particular body of knowledge and developing the skills to apply that knowledge to concrete cases. The medical profession has a code of ethics, a particularly stringent duty of service to patients, and the privilege of self-regulation granted by society (3). Society is willing to hand over to professions the social power to make final determinations on matters in which they are experts, because without the profession, certain benefits would not be available to society’s members (4).

To avoid the risk of handing over authority to a profession and having the profession use it solely for their own benefit, societies create an expectation with
regard to the exercise of expertise by professionals. The American Board of Internal Medicine, the American College of Physicians-American Society of Internal Medicine Foundation, and the European Federation of Internal Medicine describe the principle of the primacy of patient welfare as one in which physicians are dedicated to serving the interests of patients (3).

Being a physician in society carries with it particular obligations because of the importance of health care. Promotion of health and cure of disease are two widely recognized goals of medicine that are valued by patients and families. Because of the importance to patients of achieving these goals and other medical goals, such as maintenance of function and relief of suffering, physicians have been accorded access by patients to their sensitive personal information and private anatomy. This access renders patients vulnerable to the influence and power of physicians to pursue physicians’ own personal goals rather than the goals of patients (5). Thus, the practice of the profession of medicine requires a high set of ethical standards.

**Ethics of the Physician–Patient Relationship**

A core requirement for the physician in the ethical conduct of the physician–patient relationship is to respect patient autonomy—allowing the patient to control the decisions that affect his or her body and life. To promote patient autonomy, the accepted standard for decision making in the physician–patient relationship is the process of informed consent.

In this era of patient-centered care, the expectation for the physician–patient relationship is more than a minimalist version of informed consent. The ethical standard for health care professionals is to strive for shared decision making, a process of communication between patients and physicians in which they reach agreement on a specific course of treatment after patients describe their values and preferences and physicians present treatment alternatives with their attendant benefits and risks. As a result of the process, each participant better understands the relevant factors and shares responsibility in the decision (6).

Shared decision making, which represents an optimal realization of the informed consent process, requires nephrologists to make a recommendation based on the patient’s condition and known wishes or best interest. Nephrologists are not to be neutral presenters of facts. One of seven essential elements of informed consent is for physicians to use their knowledge of the patient and medical judgment to make a recommendation of a plan for treatment (7).

For the types of ethical issues raised in the two cases presented in this article, it is particularly important for shared decision making to include honest, objective disclosures by nephrologists of the evidence regarding the quality of care in dialysis units and any financial conflicts of interest. There is a legitimate role for limits on the shared decision-making process to protect the rights of patients and the professional integrity of health care professionals. Patients have the right to refuse recommendations made by their physicians. Patients also only have a choice among medically accepted and available options that are believed to have a chance of promoting the patient’s welfare. Allowing patients the ethical and legal authority to exercise their negative right to abstain from some or all medical treatment does not grant them a positive right to particular treatments that are not deemed by their nephrologists to offer a likelihood of medical benefit (8).

**Ethics of the Marketplace Versus Ethics of Professional Practice**

In a free enterprise environment, there is also another ethical standard—the ethics of the marketplace relationship. In this scenario, the health care provider is simply a seller who has no ethical commitment to give priority to the well-being of the consumer-patient. Even if the marketplace relationship leaves the consumer-patient in a worse predicament, it is successful as a marketplace relationship as long as it maximizes the interest of the seller-provider.

Obviously, this marketplace relationship directly conflicts with the ethical commitment of health professionals to place a high priority on the well-being of patients. The RPA/Forum position paper on ESRD patient solicitation speaks to this conflict as the professional’s fiduciary duty to the patient and states that physicians have “a particularly stringent duty to assure that their decisions and actions serve the welfare of their patients or clients, even at some cost to themselves” (1). The phrase “particularly stringent” does not imply that the duty is exclusive, and it does not negate other duties that physicians have; however, it does define the high degree to which a physician’s obligation to the patient’s welfare must be maintained.

Marketplace relationships can preserve consumer (patient) autonomy, because they require the seller to not falsely mislead the consumer. The Federal Trade Commission (FTC), for example, states that the professional as marketplace seller may not provide the consumer with materially misleading or false information about the product or service to be provided (9).

The only plausible justification for group A to initiate a conversation with patients about transfer to GKC would be an existing well evidenced professional judgment that group A caregivers are significantly superior to group B caregivers. This judgment would need to withstand the scrutiny of the FTC regulation on misrepresentation. If there was evidence that BDC did not meet the standards imposed by the ESRD Conditions for Coverage for Dialysis Facilities, the appropriate response would be an investigation by state regulatory authorities or an ESRD Network. Therefore, the RPA/Forum position paper includes the recommendation that genuine shortfalls from accepted care should be reported to appropriate authorities. Table 1 shows the position paper ethical principles and recommendation.

**Conflicts of Interest, Recusal, and Transparency**

A conflict of interest (COI) is potentially harmful when professionals in a relationship with a party requiring their expertise have other interests that may interfere with the proper exercise of judgment regarding the party’s well-being (10). Paradoxically, multiple and potentially conflicting interests exist in most human relationships, and therefore, simple adherence to a code of conduct requiring one to avoid the COI is not usually possible. To make the code of conduct useful, one must, after determining whether a COI exists, ascertain whether it is likely to significantly
interfere with the proper exercise of physician judgment about the patient’s wellbeing.

With respect to group A in case 1, the question is whether a financial stake in GKC is a factor likely to interfere with the proper exercise of their professional judgment when members cover for group B patients. To determine whether group A physicians, in fact, managed the patients of group B in such a way as to prevent their business interests from interfering with their professional judgment about patient wellbeing, one would first need to know the exact content of their conversations.

If group A physicians recognized that their business interests would almost inevitably interfere with their judgments about these patients’ wellbeing, they would have several options when planning their encounters with the patients that they covered.

1. **Reculsual**. The most direct way to avoid a COI likely to interfere with professional judgment is to not get involved in the situation; thus, recusing oneself is often a possibility for judges, board members, etc. However, not covering group B’s patients is not helpful in this situation, because these patients need medical care, and group B does not have privileges at the hospital to which the patients have been admitted.

2. **Refrain from solicitation**. The coverage of these patients does not require group A to initiate discussions of the comparative quality of nephrologists or different dialysis units.

3. **Transparency**. Suppose the patients themselves raise questions comparing one doctor or facility with another doctor or facility. Refusing to answer is not the best option. However, transparency is a requirement of ethics when circumstances preclude avoiding a potentially harmful COI. Professionals are obligated to openly disclose interests that might interfere with their professional judgment, enabling the patient to consider these facts when evaluating the recommendations. This practice is the same practice that is exemplified in speaking engagements and authorship of books and journals.

Therefore, group A physicians in case 1 would be obligated to provide group B patients with the following information:

1. **Full, objective, and evidence-based information about alternatives**.
2. **Careful consideration of the likely impact on interrupting continuity of care**.
3. **Disclosure of the physician’s business interest (medical directorship and financial interest)** in the matter. Disclosure and transparency are included in the position paper’s Principles of Professional Conduct.

Additionally, it is of concern when physicians have ownership of health care facilities to which they self-refer, because the consequences for patients may be negative. In the past, both comparative cost and quality indicators were worse for physical therapy and imaging center joint ventures in which physicians were involved (14–16). Despite governmental regulations instituted by the US Congress in 1992 against physician self-referral,
these findings continue to the present (17,18). It is pertinent to note, however, that none of these studies associated nephrologist joint ventures with worse quality outcomes. Some recommend legislation to ban joint venture participation in health facilities by referring physicians (14,19), but the American College of Physicians has suggested a different approach.

The American College of Physicians’ Ethics Manual suggests that it is justified for physicians to invest in or own health care facilities when capital funding and necessary services that would otherwise not be available are provided. In such situations, in addition to disclosing such interests, the Ethics Manual states that “physicians must establish safeguards against abuse, impropriety, and the appearance of impropriety” (20).

**Ethics of Intercollegial Relationships between Nephrologists**

Continuity of care requires different groups of physicians covering the same patients to cooperate effectively together. Patient solicitation is a violation of this collegial relationship, and state laws explicitly prohibit it (21,22).

The kind of competition that is perfectly reasonable in the marketplace, where there is no ethical commitment to give any priority to the customer’s wellbeing, is out of place among physicians, especially when sharing in the care of a patient. Patient care cannot be realistically provided by one caregiver at a time, and it is too complex to not entail an ethical requirement for physicians to collaborate effectively to fulfill the commitment to give high priority to the patients’ wellbeing.

All health professionals have the obligation to identify and establish intercollegial relationships that will benefit patients. Patient benefit is the reason for which society created the medical profession in the first place.

**Return to Analysis of the Cases**

In case 1, group A physicians did not strive for a shared decision-making process with regard to the recommendation to the patients to switch from BDC to GKC and fell short of ethical standards in their conduct. If patients themselves ask group A physicians about switching their care to GKC, group A physicians should provide the patients with truthful, careful, transparent, and individualized explanations of whether the benefits of transferring to a dialysis facility and set of caregivers with whom they have no history outweigh the losses that they would experience by interrupting the continuity of care with current caregivers.

Taken together, group A physicians’ acts of solicitation fall short of professional ethical behavior in three ways. They fail to meet (1) the professional ethical standard for informed consent in the physician–patient relationship, (2) the stringent duty of physicians to give priority to the patient, even if it is to their financial detriment, and (3) the minimal ethics of the marketplace, because comments that GKC is better are not supported by evidence and in fact, are materially misleading. To meet ethical standards, nephrologists other than the patient’s treating nephrologist should not approach patients to change nephrologists or dialysis facilities.

Case 2 indicates when even the patient’s treating nephrologist should not approach his/her patients to change dialysis facilities. In case 2, the conduct of nephrologist A is ethically quite problematic. There already is a well-established functioning dialysis unit in her/his town, and she/he has a direct financial COI in the establishment of the new dialysis unit, which is very likely to interfere with professional judgment; she/he has no data to suggest that the new unit in which she/he has a financial COI is any better than the present unit. Nephrologist A’s disclosure to her/his patients of her/his financial interest in the new unit has its limitations as a means to protect her/his patients; she/he violates the American Medical Association’s Code of Medical Ethics opinion on physician self-referral and the FTC regulations by misrepresenting that the care at the new unit will be better than at the present unit. Until there are data to support the superiority of the new unit over the present one, nephrologist A is not justified in recommending that her/his patients transfer their care to the new unit. Patients should be free to make their decision to transfer based on patient-specific values such as convenience.

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**References**


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