# CODE OF ETHICS OF THE AMERICAN COLLEGE OF OSTEOPATHIC SURGEONS

(PLEASE NOTE: All complaints regarding possible ethical misconduct must be in writing and sent to: EthicsComplaints@facos.org or ACOS Ethics Committee, 1680 Duke Street, Suite 500 I Alexandria, VA 22314)

Ethical principles within the ACOS are used to guide our member physicians/surgeons in their professional lives. The ACOS has a deep and effective concern for the improvement of patient care and for the ethical practice of medicine. The ethical practice of medicine establishes and ensures an environment in which all individuals are treated with respect and tolerance. Discrimination or harassment on the basis of age, sexual preference, gender, race, disease, disability, or religion, are proscribed as being inconsistent with the ideals and principles of the American College of Osteopathic Surgeons. The ACOS is organized to benefit humanity by advancing the art and science of osteopathic surgery; to promote the highest standard of professional skill and competence among surgeons; to promote the exchange of information among surgeons/physicians; to promote the highest standard of personal and professional conduct among surgeons and others; to provide the public with information about the scientific progress in surgery; to promote the purpose and effectiveness of surgeons as is consistent with the public interest.

Compliance with this Code of Ethics will be considered as one of the measures used to evaluate a member's maintenance of good professional standing, and to evaluate qualifications for membership by applicants.

## Code of Professional Conduct

As Members and Fellows of the American College of Osteopathic Surgeons, we treasure the trust that our patients have placed in us because trust is integral to the practice of surgery. Our profession is accountable to our communities and to society. As surgeons, we acknowledge that we interact with our patients when they are most vulnerable. Their trust and the privileges we enjoy depend on our individual and collective participation in efforts to promote the good of both our patients and society. During the continuum of pre-, intra-, and postoperative care, we accept the following responsibilities:

- Serve as effective advocates of our patients' needs
- Disclose therapeutic options, including their risks and benefits
- Disclose and resolve any conflict of interest that might influence decisions regarding care
- Be sensitive and respectful of patients, understanding their vulnerability during the perioperative period
- Fully disclose adverse events and medical errors
- Acknowledge patients' psychological, social, cultural, and spiritual needs
- Encompass within our surgical care the special needs of terminally ill patients

- Acknowledge and support the needs of patients' families
- Respect the knowledge, dignity, and perspective of other health care professionals
- Provide the highest quality surgical care
- Abide by the values of honesty, confidentiality, and altruism
- Participate in lifelong learning
- Maintain competence throughout our surgical careers
- Participate in self-regulation by setting, maintaining, and enforcing practice standards
- Improve care by evaluating its processes and outcomes
- Inform the public about subjects within our expertise
- Advocate for strategies to improve individual and public health through communication with government, health care organizations, and industry
- Work with society to establish just, effective, and efficient distribution of health care resources
- Provide necessary surgical care without regard to gender, race, disability, religion, social status, or ability to pay
- Participate in educational programs addressing professionalism

As members of the American College of Osteopathic Surgeons, we commit ourselves and the College to the ideals of honorable behavior and professionalism.

## Qualifications of the Responsible Surgeon

### Competencies

A surgeon should acquire and maintain competence in all six necessary general competencies identified by the American Board of Medical Specialties (ABMS) Task Force on Competence and published by the Accreditation Council for Graduate Medical Education (ACGME):[1] patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice. A responsible surgeon should demonstrate competence in the following areas:

- Patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of good health
- Medical knowledge of established and evolving biomedical, clinical, and cognate (for example, epidemiological and social-behavioral) sciences and the application of this knowledge to patient care
- Practice-based learning and improvement that involves investigation and evaluation of a surgeon's patient care, appraisal and assimilation of scientific evidence, and improvements in patient care
- Interpersonal and communication skills that result in effective information exchange and effective interaction with patients, their families, and other health care professionals
- Professionalism manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population

- Systems-based practice, manifested through actions that demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively utilize system resources to provide care that is of optimal value

Maintenance of these competencies requires a commitment to lifelong learning through self-study, formal continuing medical education, and periodic assessment.

## Commitment to Scientific Knowledge and Research

The surgeon should base care on the best available scientific evidence and should seek and give consultation appropriately. Responsible surgeons should uphold scientific standards, promote research, and create new knowledge and strive for the appropriate use of this knowledge and these findings.

## Commitment to Maintain Fitness

The surgeon should maintain a satisfactory level of mental and physical fitness. A surgeon who becomes temporarily impaired by illness or injury, chemical dependence, fatigue, or other conditions that affect surgical judgment or performance should arrange for a qualified colleague to assume his or her clinical responsibilities until the impairment has been resolved.

## Eligibility to Perform Surgical Procedures

The responsible surgeon's eligibility to perform a surgical procedure is based upon the surgeon's education, training, experience, and demonstrated proficiency. The surgeon should be a member in good standing of the department or service through which privileges are to be recommended. The granting and continuation of surgical privileges should be based upon the medical staff member's qualifications and upon a record of appropriate performance as evaluated by an established peer review mechanism and medical audit process.

Surgeons are expected to study and evaluate new procedures and to become knowledgeable of and proficient with advances that are appropriate. Technical skill alone is insufficient to qualify a surgeon to perform new procedures. Procedural skills should be acquired within the context of in-depth knowledge about the disease to be treated.

## Educational Requirements

Only qualified surgeons can deliver high-quality surgical care to the sick and injured patient. Qualified surgeons are those physicians who have completed a surgical residency/fellowship approved by the AOA or ACGME; are certified or qualified for examination by a surgical board recognized by the AOBS, or the ABMS; and who maintain continuing education and proficiency in their specialty.

### Confining Practice within a Specialty

Qualification of a surgeon as a specialist carries the commitment and responsibility to conduct a surgical practice that conforms to his or her defined specialty. The appropriate surgical specialty board recognized by the AOBS or the ABMS determines a surgeon's scope of practice. Procedures performed are dictated by the guidelines set by a specialty board. Performing procedures outside of the field defined by a specialty board mandates that the surgeon obtain additional education and experience, as well as any appropriate certification. The College may take disciplinary action against members who engage in surgical procedures outside their scope of practice as previously described or who falsely advertise their training, certification, or experience.

In those instances in which no appropriately trained surgeon is available to perform a necessary procedure, it may be necessary for the surgeon to engage in practice outside of his or her specialty limits. Appropriate consultation and/or assistance should be obtained whenever possible. These decisions must be dictated by what is in the best interests of the patient.

## Relation of the Surgeon to the Patient

### Informed Consent

Informed consent is more than a legal requirement. It is a standard of ethical surgical practice that enhances the surgeon/patient relationship and that may improve the patient's care and the treatment outcome. Surgeons must fully inform every patient about his or her illness and the proposed treatment. The information must be presented fairly, clearly, accurately, and compassionately. The surgeon should listen carefully to understand the patient's feelings and wishes and should answer all questions as accurately as possible. The informed consent discussion conducted by the surgeon should include:

- The nature of the illness and the natural consequences of no treatment.
- The nature of the proposed operation, including the estimated risks of mortality and morbidity.
- The more commonly known complications, which should be described and discussed. The patient should understand the risks as well as the benefits of the proposed operation. The discussion should include a description of what to expect during the hospitalization and post-hospital convalescence.
- Alternative forms of treatment, including non-operative techniques.
- A discussion of the different types of qualified medical providers who will participate in their operation and their respective roles.
- Respect a patient's request for additional opinions.

The surgeon should not exaggerate the potential benefits of the proposed operation nor make promises or guarantees. For minors and incompetent adults, parents or

legal guardians must participate in the informed consent discussion and provide the signature for elective operations. Any adequately informed, mentally competent adult patient can refuse any treatment, including operation. When mentally incompetent patients or the parents (guardians) of minors refuse treatments, jeopardizing the patient's best interests, the surgeon can request legal assistance.

When patients agree to an operation conditionally or make demands that are unacceptable to the surgeon, the surgeon may withdraw from the case.

## Scope of Surgical Care

Surgical care includes providing preoperative diagnosis and care, educating the patient about the risks and benefits of operation and obtaining informed consent, selecting and performing the operation, and providing postoperative surgical care.

### Preoperative Diagnosis and Care

Because a team of specialists undertakes much of modern patient care, non-surgeon physicians often may conduct the initial evaluation of patients. However, the surgeon bears the ultimate responsibility for determining the need for and the type of operation. In making this decision, the surgeon must give precedence to sound indications for the procedure over pressure by patients or referring physicians or the financial incentive to perform the operation. The surgeon is responsible for the patient's safety throughout the preoperative, operative, and postoperative period, including ensuring the elimination of risk of wrong site, wrong procedure, and wrong patient surgery.

### The Operation—Intraoperative Responsibility of the Primary Surgeon

The primary attending surgeon is personally responsible for the patient's welfare throughout the operation. In general, the patient's primary attending surgeon should be in the operating suite or should be immediately available for the entire surgical procedure. There are instances consistent with good patient care that are valid exceptions. However, when the primary attending surgeon is not present or immediately available, another attending surgeon should be assigned to be "immediately available."

The definitions at the end of this Statement provide essential clarification for terms used herein.

### Concurrent or Simultaneous Operations

Concurrent or simultaneous operations occur when the critical or key components of the procedures for which the primary attending surgeon is responsible are occurring all or in part at the same time. The critical or key components of an operation are determined by the primary attending surgeon. A primary attending surgeon's involvement in concurrent or simultaneous surgeries on two different patients in two different rooms is inappropriate.

## Overlapping Operations

Overlap of two distinct operations by the primary attending surgeon occurs in two general circumstances.

The first and most common scenario is when the key or critical elements of the first operation have been completed, and there is no reasonable expectation that the primary attending surgeon will need to return to that operation. In this circumstance, a second operation is started in another operating room while a qualified practitioner performs noncritical components of the first operation—for example, wound closure—allowing the primary surgeon to initiate the second operation. In this situation, a qualified practitioner must be physically present in the operating room of the first operation.

The second and less common scenario is when the key or critical elements of the first operation have been completed and the primary attending surgeon is performing key or critical portions of a second operation in another room. In this scenario, the primary attending surgeon must assign immediate availability in the first operating room to another attending surgeon.

The patient needs to be informed in either of these circumstances. The performance of overlapping procedures should not negatively affect the seamless and timely flow of either procedure.

## Multidisciplinary Operations

Contemporary surgical care often involves a multidisciplinary team of surgeons. During such operations, it is appropriate for surgeons to be present only during the part of the operation that requires their surgical expertise. However, an attending surgeon must be immediately available for the entire operation.

### Delegation to Qualified Practitioners

The surgeon may delegate part of the operation to qualified practitioners including but not limited to residents, fellows, anesthesiologists, nurses, physician assistants, nurse practitioners, surgical assistants, or another attending under his or her personal direction. However, the primary attending surgeon's personal responsibility cannot be delegated. The surgeon must be an active participant throughout the key or critical components of the operation. The overriding goal is the assurance of patient safety.

## Procedure-Related Tasks

A primary attending surgeon may have to leave the operating room for a procedure-related task, such as review of pertinent pathology ("frozen section") and diagnostic imaging, discussion with the patient's family, and breaks during long procedures. The surgeon must be immediately available for recall during such absences.

## Unanticipated Circumstances

Unanticipated circumstances may arise during procedures that require the surgeon to leave the operating room before completion of the critical portion of the operation. In this situation, a backup attending surgeon must be identified and available to come to the operating room promptly.

Circumstances in this category might include sudden illness or injury to the surgeon, a life-threatening emergency elsewhere in the operating suite or contiguous hospital building, or an emergency in the surgeon's family.

If more than one emergency occurs simultaneously, the attending surgeon may oversee more than one operation until additional attending surgeons are available.

## Surgeon-Patient Communication

The surgical team involved in an operation is dependent on the type of facility where the operation is performed and on the complexity of the surgical procedure. At a freestanding outpatient surgery center, many procedures are performed solely by the primary attending surgeon with no assistant. In contrast, a complex procedure at an academic medical center may involve multiple qualified medical providers in addition to the primary attending surgeon. As part of the preoperative discussion, patients should be informed of the different types of qualified health care professionals who will participate in their operation (assistant attending surgeon, fellows, residents and interns, physician assistants, nurse practitioners, and so forth) and their respective role should be explained. If an urgent or emergent situation arises that requires the surgeon to leave the operating room unexpectedly, the patient should be informed subsequently.

Definitions
In an effort to provide some standardization of nomenclature, the following definitions are provided:

*Backup surgeon/surgical attending*
The qualified surgical attending who has been designated to provide immediately available coverage for an operation, during a period when the primary surgeon might be unable to fill this role.

*Concurrent or simultaneous operations*
Surgical procedures when the critical or key components of the procedures for which the primary attending surgeon is responsible are occurring all or in part at the same time.

*"Critical" or "key" portions of an operation*
The "critical" or "key" portions of an operation are those stages when essential technical expertise and surgical judgment are

necessary to achieve an optimal patient outcome. The critical or key portions of an operation are determined by the primary attending surgeon.

*Immediately available*
Reachable through a paging system or other electronic means, and able to return immediately to the operating room. This term should be defined more completely by the local institution.

*Informed consent*
Described in American College of Surgeons Statements on Principles

*Multidisciplinary operations*
An example of a multidisciplinary operation is a procedure in which a surgeon of one specialty provides the exposure required by a second surgeon who performs the main surgical intervention (such as a general or thoracic surgeon providing exposure for a neurosurgeon or orthopedist to operate on the spine). Another example would be an operation that requires the involvement of two or more surgeons of different specialties (such as chest wall or head and neck resection followed by plastic surgical reconstruction, face or hand transplantation, and repair of complex craniofacial defects).

*"Overlapping or sequenced" operations for surgeons*
The practice of the primary surgeon initiating and participating in another operation when he or she has completed the critical portions of the first procedure and is no longer an essential participant in the final phase of the first operation. These are by definition surgical procedures where key or critical portions of the procedure are occurring at different times.

*Physically present*
Located in the same room as the patient.

*Primary attending surgeon*
Considered the surgical attending of record or the principal surgeon involved in a specific operation. In addition to his or her technical and clinical responsibilities, the primary surgeon is responsible for the orchestration and progress of a procedure.

*Qualified practitioner*
Any licensed practitioner with sufficient training to conduct a delegated portion of a procedure without the need for more experienced supervision and who is approved by the hospital for these operative or patient care responsibilities.

## Postoperative Care

The responsibility for the patient's postoperative care rests primarily with the operating surgeon. The emergence of critical care specialists has provided important support in the management of patients with complicated systemic problems. It is important, however, that the operating surgeon maintain a critical role in directing the

care of the patient. When the patient's postoperative course necessitates the involvement of other specialists, it may be necessary to transfer the primary responsibility for the patient's care to another physician. In such cases, the operating surgeon continues to be involved in the care of the patient until surgical issues have been resolved. Except in unusual circumstances, it is unethical for a surgeon to relinquish responsibility for the postoperative surgical care to any other physician who is unqualified to provide similar surgical care.

If the operating surgeon must be absent during a portion of the critical postoperative period, coverage should be provided by another surgeon who is skilled and who can render surgical care—including reoperation, if necessary—equivalent to that provided by the surgeon who performed the operation. The patient should be informed of this arrangement in advance.

The surgeon's responsibility extends throughout the surgical illness. When this period has ended, it is appropriate for the surgeon to relinquish the responsibility for management of the patient. When a patient is ready for discharge from the surgeon's care, it may be appropriate to transfer the day-to-day care to another physician.

## Continuity of Care of the Surgical Patient

The surgeon will ensure that the surgical patient receives appropriate continuity of care. An ethical surgeon should not perform elective surgery at a distance from the usual location where he or she operates without personal determination of the diagnosis and of the adequacy of preoperative preparation. Postoperative care should be rendered by the operating surgeon unless it is delegated to another physician who is equivalently qualified to continue this essential aspect of total surgical care.

It is recognized that for many operations performed in an ambulatory setting, the pattern of the patient's postoperative visits to the surgeon may vary considerably; it is, however, the responsibility of the operating surgeon to establish communication to maintain proper continuity of care. Similar circumstances may apply when patients travel great distances for elective surgery.

Emergency surgery performed in locations unusual for the surgeon may be necessary on occasion, but habitual or even frequent performance of operations under these circumstances cannot be condoned. If the condition of the patient permits and additional skills are required, the patient should be transported to a medical center where adequate resources and appropriately trained health care professionals are available.

## Freedom of Choice

Patients usually choose their surgeons, and surgeons, in turn, may accept or refuse patients. In emergencies or when required by law, the surgeon should provide the needed care and arrange for follow-up care. Certain circumstances (for example, the military and health maintenance organizations) restrict freedom of choice, and patient and surgeons are assigned. An ethical surgeon should abstain from a system that denies serving the best interests of the patient by refusing referral out of the system.

Freedom of choice means that either the patient or the surgeon may terminate the physician-patient relationship. When a patient exercises this right, the surgeon should transfer copies of the medical record to the new surgeon or another appropriate physician. When a surgeon exercises this right, he or she should notify the patient in writing and provide copies of the medical record to the new surgeon or physician. All parties should cooperate to ensure continuity of care during the transfer.

## Confidentiality of Medical Records

Patient confidentiality is a fundamental tenet of medical care. The information in the medical record belongs to the patient but is shared with those health care professionals responsible for providing care. However, in most jurisdictions, the records belong to the physician or institution that compiles and maintains them for the caregivers. Access to medical records by caregivers, insurers, government, and other parties places patient privacy in jeopardy. Nevertheless, every health care worker is honor bound to protect patients' confidentiality. U.S. law—the Health Insurance Portability and Accountability Act (HIPAA), which went into effect April 14, 2003—protects all medical records from unauthorized disclosure. All surgeons in the U.S. are obliged to understand and abide by HIPAA regulations. HIPAA provides for the use of medical information in the public interest—for example, reducing public health risks and accumulating vital statistics.

Surgeons should avoid disclosing identifiable health care information to any person without authorization from the patient. Also, discussion of identifiable patient information in public places is unethical.

## Conflict of Interest

The physician-patient relationship requires that the patient's interests supersede all other interests, including the personal and financial interests of the surgeon, the corporate and financial interests of the payor, and the corporate and financial interests of all vendors including pharmaceutical companies and the manufacturers of instruments, equipment, prosthetic devices, supplies, and services. Modern marketing strategies and tactics place extraordinary pressure on surgeons. Surgeons must strive to maintain the knowledge, insight, and discipline required to keep the patient's interests above all others.

## Unnecessary Operations

No operation should be performed without suitable justification. It is the surgeon's responsibility to perform a careful evaluation, including consultation with others when appropriate, and to recommend surgery only when it is the best method of treatment for the patient's problem.

## Quality Assurance

Quality assessment and improvement have become integral concepts in the effort to improve patient outcome. Hospitals have established formal committees to assess and improve the quality of patient care. Members are strongly encouraged to be actively

involved as leaders of quality assessment and improvement activities in their own hospitals.

### Surgical Fees

In the U.S., government and private insurance carriers establish many professional fee schedules. Payments for services may require documentation. Surgeons should accurately document services in compliance with government standards.

Members of the College are urged to hold to the traditional principles of ethics and compassion in providing patient care and must not participate in any arrangements that encourage unnecessary operations or referrals made primarily for reasons other than optimal patient care.

Surgeons provide many uncompensated services, particularly when patients are unable to pay. If the surgeon expects the patient to personally pay a fee, he or she or a qualified representative should discuss the fee with the patient before the operation. Fees should be commensurate with services rendered.

## Interprofessional Relations

### Surgeons and Colleagues

The surgeon's relationship with colleagues is often an important part of ensuring the best care is provided to the patient. No single physician or surgeon can be an expert in all areas of medicine. Team medicine has become the norm, and surgeons have a responsibility to work with colleagues.

Surgeons who have intimate personal relationships with individuals at their workplace should seek to minimize their supervisory responsibilities with those individuals and should excuse themselves from the evaluation process.

### Discrimination or Harassment

The ethical practice of medicine establishes and ensures an environment in which patients, staff, colleagues, students, residents, and all other individuals are treated with respect and tolerance. Discrimination, harassment, or creation of a hostile working environment on the basis of personal attributes, including but not limited to age, sexual preference, gender, race, disease, disability, or religion, is inconsistent with the ideals and principles of the American College of Osteopathic Surgeons.

### Consultations

The surgeon is responsible for obtaining consultation for his or her patients when appropriate, and for providing consultation for the patients of colleagues when requested. These consultations may be for opinion only, to assist with management, or for the transfer of care. The patient should be informed in any instance that requires such a consultation. An appropriate report that is, by letter or by placement in a common chart or medical record, should be made available to the referring physician.

### Payment

Payment of any kind, or by any method, by the surgeon to a referring physician to induce referral of a patient (fee splitting) is unethical (and usually is illegal). Although a number of practices and procedures that represent modified and subtle forms of fee splitting now exist, surgeons are responsible for recognizing and avoiding them.

Payment to another physician for required assistance that is provided at operation may be made properly to that assistant by the patient. The patient should be informed of the nature and amount of the payment. The means and mechanisms of such payment may be dictated by certain contractual obligations of the patient and the surgeon.

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## Medical Education

It is vitally important that the practicing surgeon keep up with changes and advances in the art and science of his or her field of surgery and of medicine in general. To do so, members of the College should engage in a lifelong program of education and self-assessment.

### Continuous Medical Education and Professional Development

A member of the College should meet the obligation for continuous education and development using multiple pathways. The goal of continuous education and self-assessment is to assist the Member/ Fellow in providing high-quality care to the surgical patient.

The member should engage in continuing educational programs to ensure a high level of skill in the domains of medical knowledge, technical proficiency, professionalism, interpersonal communications, and systems-based practice.

The member may achieve these educational goals by attending programs sponsored by the College or other scientific organizations, through continuing study of current peer-reviewed journals and texts, and through participation in other continuing education programs. Ideally, the member should engage in a variety of educational programs, including, at least once per year, programs that allow an interchange of ideas with faculty and other participants.

Acquisition of skills in new procedures should be fostered by attendance at courses with both didactic and hands-on training sessions. The member should seek appropriate proctoring of cases as new procedures are added to the surgeon's surgical portfolio. Continuous self-appraisal of surgical outcomes is strongly encouraged, with the goal of improving patient outcomes.

The member will maintain certification by a member board of the AOBS or ABMS throughout his or her surgical career. Additionally, the College encourages periodic, voluntary self-assessment of medical knowledge by non-proctored testing formats.

### Students/Residents

It is the responsibility of surgeons, as members of the medical profession, to be "teachers" of patients, medical students, residents, and other health care professionals. Surgeons have a special responsibility to supervise resident training because of the unique characteristics of surgical conditions and operations.

## Surgeons and Society

### Surgical Research

Progress in medical care depends on research that often includes an informed collaboration between patients and physicians. Research should be distinguished from innovations that are departures from standard practice.[2-4] Although new practices that are designed solely to benefit a patient may be described as "experimental" in the sense that they are new and untested, that does not automatically place them in the category of research. Research implies an activity intended to test a hypothesis so that scientific conclusions may be drawn. Research should be conducted under a formal written protocol that sets forth an objective and a set of procedures designed to reach the objective. When an innovation departs significantly from standard or accepted practice, the innovation should become the object of formal research at an early stage to determine its safety and effectiveness. It is the responsibility of individual surgeons and of medical practice committees to see that major innovations are incorporated into formal research protocols.

When applicable, humanely conducted animal studies should precede the testing of new techniques in humans. Before research programs involving human beings are undertaken, an impartial, qualified committee on human investigation should approve the protocol and the process for obtaining informed consent. Human research must meet the highest ethical standards.[2-4] The primary principles of patient autonomy and safety must be preserved. Every patient has the right to understand completely the nature, as well as the risks, of such research activities and has the right to withdraw from the investigation at any time. Members shall not claim as his or her own intellectual property that which belongs to others. Plagiarism or the use of others' work without attribution is unethical.

### Scientific Publications

Presentation of results of an investigation must be governed by the principles of ethics. All authors must assume full public responsibility for the material presented. Surgeons should first report research contributions to professional audiences of peers and/or to peer-reviewed scientific publications. Many scientific organizations, scientific publications, and research facilities have rules governing news releases and require that approval be obtained before a news release is distributed to the media. In the

event that an individual patient is identified, approval should be obtained from the physician who is providing care for any identified patient, and, equally important, permission should be obtained from the patient. The patient's right to privacy must be protected.

## Public Relations

A surgeon's release of material to communications media or nonprofessional publications should be designated only for education and public information. Such releases must be accurate. They must not convey false, untrue, deceptive, or misleading information through statements, testimonials, photographs, graphics, or other means, and they must contain sufficient supporting material information. Releases must not create unjustified expectations of results. If treatment through a surgical procedure involves significant risks, realistic assessment of the safety and benefit of the procedure must be included, as well as the availability of alternative treatments and their benefits and hazards. Releases must not misrepresent a surgeon's credentials, training, experience, or ability, and should contain only claims that can be substantiated. If a surgeon is reimbursed or sponsors a communication, that fact must be made clear to the public.

## Advertising

Advertising is legal; prohibitions of truthful advertising are considered to be restraints of trade. An advertisement may include information about specialty training, board certification, type of practice, office hours, languages spoken, and other such information that might assist the patient in contacting the surgeon. Advertising must be truthful, both in terms of what is said and in what is not said. Similarly, any illustrations or photographs must be truthful. Advertising should not entice patients to undergo operations if better alternative treatments are available.

## Expert Testimony

When appropriate, physicians have an obligation to testify in court as expert witnesses. Physician expert witnesses are expected to be impartial and should not adopt a position as an advocate or partisan in the legal proceedings. The physician acting as an expert witness must have a current, valid, and unrestricted license to practice medicine in the state, province, or region in which he or she provides surgical services. The physician acting as an expert witness should be familiar with the standard of care provided at the time of the alleged occurrence and should be actively engaged in practice of the specialty or the subject matter of the case during the time the testimony or opinion is provided. The specialty of the physician acting as an expert witness should be appropriate to the subject matter in the case. The physician acting as an expert witness is ethically and legally obligated to tell the truth. Compensation of the physician acting as an expert witness should be reasonable and commensurate with the time and effort given to preparing for depositions and court appearances. It is

unethical for a physician acting as an expert witness to link compensation to the outcome of the case.

## Impaired Physicians

It is every surgeon's responsibility to safeguard patients from harm as a result of the action or decisions of a colleague impaired by illness, aging, or substance abuse. In addition, there is a collegial and a medical responsibility to assist the impaired colleague in obtaining care, even if the individual must be reported to the appropriate authority to begin the steps toward adequate care.

## Incompetent Surgeons

When incompetent patient management is recognized, the surgeon's responsibility is to assist the regular institutional peer review mechanism in remedying the situation. Physical, moral, or mental impairment that renders a colleague incompetent to care for patients, or that is associated with fraud or other malfeasance, should be disclosed to protect patients and society. On the other hand, it is indefensible to disparage the actions, knowledge, or skills of another physician for malicious reasons.

Each Member may be subject to disciplinary action, including expulsion, if:

A. The member's right to practice medicine is limited, suspended, terminated, or otherwise affected in any state, province, or country for violation of a medical practice act or other statute or governmental regulation or the member is disciplined by any medical licensing authority.

B. The member fails to inform ACOS that the member's right to practice medicine has been limited, suspended, terminated, or otherwise affected in any state, province, or country for violation of a medical practice act, other statute or governmental regulation or, the member has been disciplined by any medical licensing authority.

C. The member is convicted of (or pleads guilty to) a felony or any crime relating to or arising out of the practice of medicine or involving moral turpitude.

D. The member engages in sexual misconduct in the practice of medicine.

E. The member is involved in improper financial.

F. The member uses, participates in or promotes the use of any form of public communication (as defined in Glossary to the Code) or private communication (as defined in the Glossary to the Code) containing a false, fraudulent, deceptive, or misleading statement or claim, including a statement or claim which contains a misrepresentation of fact, or fails to state any fact that is necessary to make the statement not deceptive or misleading, when considered as a whole.

G. The member performs an unjustified surgical operation or a surgical operation that is not calculated to improve or benefit the patient.

H. The member performs a surgical operation or operations under circumstances in which the responsibility for diagnosis or care of the patient is delegated to another who is not qualified to undertake it.

I. The member engages in unprofessional conduct in violation of the General Principles of the Code.

Glossary For purposes of this Code and unless the context otherwise requires,

A. "Electronic Media" includes websites, social media forums, blogs, video streams, discussion boards, digital platforms and any means of communication over the internet or similar virtual technology or networks.

B. "Private communication" includes any information, written or otherwise, that is disseminated by a member and not made known to the general public or nor intended to be made known to the general public at the time it was made.

C. "Public communication" includes any information transmitted orally, in writing, or through Electronic Media, the primary purpose of which is to communicate with the public, or a segment thereof.

D. "Public communications media" includes, but is not limited to, Electronic Media, television, radio, recorded video or motion picture, telephone, written correspondence, electronic mail/e-mail (other than those which are which are Private Communications), print (i.e. newspaper, magazine, book), marketing materials and branding (i.e. directory, business card, professional announcement card, office sign, letterhead, telephone directory listing or professional notice).

E. "Solicitation" is a communication to a specific individual to attract him or her as a patient.

References


1. Accreditation Council for Graduate Medical Education (ACGME). General Competencies Vers. 1.3 (Approved September 1999). Accreditation Council for Graduate Medical Education website. Available at: https://asts.org/docs/default-source/education/rrc-core-competencies.pdf. Accessed June 2016.
2. National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research. *The Belmont Report: Ethical Principles and Guidelines for the Protection of Human Subjects of Research.* Washington, DC: U.S. Government Printing Office; 1979.
3. World Medical Association. Declaration of Helsinki. Adopted by the 18th World Medical Assembly, Helsinki, Finland, June 1964, and amended by the 29th World Medical Assembly, Tokyo, Japan, October 1975; 35th World Medical Assembly, Venice, Italy, October 1983; and the 41st World Medical Assembly, Hong Kong, September 1989.

4. The Nuremburg Code (from Trials of War Criminals before the Nuremburg Military Tribunals under Control Council Law No. 10). Washington, DC: U.S. Government Printing Office; 1949–1953.

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