SURGICAL ETHICS CHALLENGES

James W. Jones, MD, PhD, MHA, Surgical Ethics Challenges Section Editor

Ethics of professional courtesy

James W. Jones, MD, PhD, MHA,[a] **Laurence B. McCullough, PhD,**[b] and **Bruce W. Richman, MA,**[b]
Houston, Tex; and Columbia, Mo

A senior physician whose wife you treated surgically has called your office, irate over receiving a bill for your services. The procedure was a complex repair of a type IV thoracoabdominal aneurysm. The patient did very well and experienced no complications following surgery. You approved the invoice your business office sent to her for the standard 20% co-pay specified in her health insurance coverage. Her husband is a prominent local internist who has regularly referred cases to you over the years. How should you respond?

A. The co-pay should be waived as a professional courtesy.
B. Explain that your biller made a mistake and write it off.
C. Write it off in consideration of past and future referrals from her husband.
D. Write it off for the good will you will gain in the medical community
E. Cite your contractual responsibility to the insurer and explain that the charge cannot be waived.

The origin of professional courtesy expressed through dismissal of professional fees dates back to ancient codices of medicine beginning with Hippocrates.[1] Thomas Percival's classic 1803 treatise on medical ethics enthusiastically endorsed complimentary professional care: "All members of the profession, including apothecaries as well as physicians and surgeons, together with their wives and children, should be attended gratuitously."[1] The 1847 and 1949 editions of the American Medical Association's Code of Ethics endorse what has come to be known as professional courtesy in withholding charges for treatment of medical colleagues and their families, largely to discourage self-treatment.[1]

Professional medical courtesy has not been just an ideal or abstract moral norm; it has long been a practice standard. As recently as a decade ago, 96% of physicians polled reported that they gave professional courtesy to other physicians and their families through free or discounted care.[2] Further, the number of nonpsychiatrist physicians giving professional courtesy was noted to have changed little over the years.

The ethical justification for this practice in the histories of medicine and of medical ethics is obscure. One historical aspect of the justification is quite practical: physicians' and surgeons' fees were often beyond the economic reach of all but the very well-to-do, and physicians, with just a few exceptions, were not within that group until relatively recently. Indeed, physicians often came from lower social classes and struggled in a mercilessly competitive profession for market share and economic survival. Only in the last half of the twentieth century have physicians in developed countries routinely achieved upper-middle-class economic status.[3] Professional courtesy served to keep physicians from treating themselves and their families.

This practical justification has an ethical dimension: professional courtesy was a form of charity. This interpretation is supported by Percival's added assertion that professional courtesy should also be extended to the clergy and their families because, like physicians, their work was characterized by benevolence and they lived in economically straitened circumstances. Physicians might have been more economically secure than the clergy, but not by much.

With the advent of professional licensure, which granted allopathic and osteopathic physicians monopoly control over medicine, and with the introduction of third-party private insurance and government direct payment programs like Medicaid and Medicare, physicians now enjoy a remarkable and enviable level of prosperity and economic security. Professional courtesy can no longer be justified as aid to economically strapped colleagues.

Moreno and Lucente[1] suggest that professional courtesy promotes professional solidarity, but this claim stimulates some skepticism. Although the custom of professional courtesy emerged from guild practices of charitable interest in one another's welfare, our professional affiliations no longer take the form of extended families, nor is our profession widely beset by those who do not practice it. Protecting self-interest by promoting the good will of colleagues may be a shrewd business practice, but it is quite

From the Center for Medical Ethics and Health Policy, Baylor College of Medicine,[a] and the Department of Psychiatry, University of Missouri.[b]
Correspondence: James W. Jones, MD, Center for Health Policy and Medical Ethics, Baylor College of Medicine, One Baylor Plaza, Houston, TX 77030 (e-mail: jwjones@bcm.tmc.edu).
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removed from the sense of solidarity that has substantive ethical content, namely the nurturance of professional integrity in the care of patients. Claims that professional courtesy maintains and strengthens professionalism seem to imbue the practice with an unearned virtue.

Moreno and Lucente also note that professional courtesy may not be without clinical consequence, in the sense that it may result in physicians and their families being over-treated. They further note professional courtesy insulates physicians from the realities of medical care costs, desensitizing them to a major societal concern affecting access to care and compliance with treatment plans.

Many health insurance contracts make moot the entire question of professional courtesy by simply prohibiting the waiver of co-payments and fees. In the presence of such provisions, courtesy becomes not only an ethical issue between physician and patient/colleague, but a legal and ethical issue between physician and the contracting third-party payer. Insurers hope that the mandatory co-pay will serve as a slight disincentive to frivolous over-use of the medical care system. Although physicians are not in the business of discouraging patients from seeking care, we all understand the risks of overtreatment and the burdens that the worried well can place upon our time and effectiveness. Furthermore, we should all be fully familiar with the legal and ethical responsibilities entailed in any contract we sign. Having agreed to participate in plans which prohibit waiver of prescribed co-payments, we surrender our discretion to administer professional courtesy.

However, there appears not to be much of a case for professional courtesy, as a practical or legal matter. At the very least, its advocates bear the burden of proving an ethical justification for it. Options A, B, and C are all forms of professional courtesy that ignore safeguards the co-payment system is intended to defend, and may constitute insurance fraud. Option B first abandons a legitimate principle and compounds the error by being deceptive about it. Option C disregards the ethical consideration entirely in the service of financial self-interest. Option D represents the obsolete guild rationalization and violates contracts.

Option E is the ethically justified response to this case, to which a preventive ethical approach should be added. Physicians should make clear to their colleagues and to family members of colleagues that, while professional courtesy may have had a rationale in the past, especially to relieve economic burdens that could be quite real, it no longer does so. Colleagues will also understand the ethical obligation to abide by the terms of insurance contracts and the quite legitimate self-interest in not committing criminal fraud. Such a preventive ethics approach is crucial because it helps to control the potential economic conflict of interest associated with this patient's husband as a referral source for the surgeon. Pursuit of such economic self-interest as the surgeon's primary motivation undermines professional integrity from within. Percival taught that medicine is a public trust that physicians are obligated to maintain; it is an obligation inconsistent with referral preservation and income as prime considerations in determining the physician's choices.

The ethics of government or private insurer imposition of mandatory co-payments is not a topic to be addressed in the present article but requires consideration.[4] There may remain, however, special circumstances in which the physician should maintain the discretion to waive co-payments if they impede a patient's access to needed care.

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