



Ethics of minimally invasive spine surgery in an ambulatory surgery center setting

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Submitted Mar 05, 2019. Accepted for publication Apr 12, 2019.

doi: 10.21037/jss.2019.04.06

View this article at: <http://dx.doi.org/10.21037/jss.2019.04.06>

Within the last few decades, there has been a shift in routine spine procedures from the inpatient to outpatient setting. In response to the transition, a surge in ambulatory surgery centers (ASCs) has closely followed (1). The reason for the movement is considered to be two-fold: (I) the advent of minimally invasive techniques and (II) financial incentives for surgeons to operate and own ASCs. Compared to traditional open spinal procedures, the adaption of minimally invasive techniques are associated with decreased postoperative pain and narcotics usage, allowing for accelerated recovery and a shorter postsurgical stay (2). Additionally, compared to the traditional hospital surgical setting, ASCs provide high quality care in a cost-effective manner. The outpatient surgery model promotes physician participation in health care decision-making and allocation of resources (3,4). However, in light of these changes, an ethical dilemma has entered the spotlight as the financial stakes in surgical facilities may potentially lead to self-referral practices.

According to the Ambulatory Surgery Center Association, physicians have at least partial ownership in 90% of ASCs nationwide in conjunction with private investors and hospital corporations (5). As owners of an ASC, surgeons have greater involvement in management decisions, more control over operating room schedules, and overall improved workflow efficiency. Outpatient centers can have turnover times as little as 20 minutes, which allows for greater overall productivity compared to over an hour at some hospital settings. Due to this efficiency alone, some surgeons have experienced a 30% increase in their incomes (3). Furthermore, surgeons not only reap benefits

from their own professional fees but are entitled to share profits from ancillary outpatient services including imaging and physical therapy. Thus, an increasing number of spine surgeons have sought investments in ASCs as they allow for a lucrative addition to their existing salaries.

Physician ownership of surgical facilities and self-referral practices have been a controversy for a few decades now. In 1989, the passage of the Stark Laws prohibited physicians from referring Medicare and Medicaid patients to themselves or relatives with financial interests in the clinical or hospital setting (3,6). Similarly, about half of the states have applied similar sanctions for privately insured patients (4). In relation, current laws prohibit self-referral for laboratory, therapy, radiology, prosthetics, and prescription drugs, however, there are no regulations that prohibit physicians from having ownership interest in an ASC as a whole (3). Although further guidelines require physician owners of multispecialty ASCs to perform at least one-third of their procedures at the facility, there are no regulations for single-specialty ASCs, which are the most common amongst outpatient spine practices.

Critics argue physician ownership may lead to improper referral practices and incentives to perform unnecessary diagnostic tests and procedures (7). According to a recent study, physician ownership of ASCs has been linked to higher volume of surgeries performed in the outpatient setting (8). As owners of ASCs, surgeons have the incentive for a more judicious patient selection and to refer patients with better insurance to their facilities. Additionally, they may schedule more profitable procedures at the ASC versus the hospital. However, critics believe this may result in

performing more complex cases than otherwise intended, leading to a greater risk in treating patients in the outpatient environment (8).

Although ownership of ASCs plays a role in patient selection and referral practices, it may be important for surgeons to disclose their financial interests to their patients. In 2008, the Centers for Medicare and Medicaid Services (CMS) issued a regulation for full disclosure of financial conflicts that physicians may have with hospitals (6). In relation, a recent survey of patient perceptions of physician disclosures established that patients value the transparency of ownership and believed that it increases trust between the patient and his or her physician (9). With this rhetoric in mind, surgeons with financial stakes in ASCs may benefit from disclosing their interest in a similar fashion as set forth by the CMS. By these regulations, both the physician and the surgery center should disclose ownership interests during the first patient encounter. Additionally, the ASC should provide a complete list of physician owners or members of immediate family members that have financial stake in the surgical facility upon request by the patient (7).

Although advances in minimally invasive techniques combined with physician ownership of ASCs has lead to a dramatic increase in routine surgeries being performed in an outpatient setting, the ethical dilemma should not be ignored. As a financial stake in the ASCs may incentivize surgeons to maximize operating volume in the outpatient environment, the relationship between the surgeon and patient should be maintained through accurate disclosing of conflicts. Surgeons should be encouraged to share their ownership interests, as this will likely improve transparency and build a stronger rapport with patients.

Acknowledgements

None.

Footnote

Conflicts of Interest: The authors have no conflicts of interest to declare.

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Cite this article as: Patel DV, Yoo JS, Singh K. Ethics of minimally invasive spine surgery in an ambulatory surgery center setting. *J Spine Surg* 2019;5(Suppl 2):S204-S205. doi: 10.21037/jss.2019.04.06