Ethics in Medical Practice

With Special Reference to Dermatology
This booklet of information on medical ethics is prepared and sanctioned by the American Academy of Dermatology. Its focus is on the practical issues or problems that may influence the ethical behavior and professional conduct of dermatologists in clinical practice. An exposition of biomedical ethics, that segment of comparative ethics dealing with philosophic considerations in the practice of medicine, is not possible in this brief publication. Moreover, practices relating to medical etiquette or custom, which are not regarded as part of medical ethics, are not discussed. It is recognized that although the basic principles of medical ethics are not likely to change significantly over the years, societal influences, among others, may dictate modifications or additions to the guidelines presented herein. The Academy welcomes suggestions and comments from its members as future editions of this booklet are prepared.

INTRODUCTION

While ethical principles governing the close relationship between physicians and their patients have been examined since early recorded history, interest in the rules of professional conduct has intensified dramatically in recent years. Physicians of this era must practice in a changing and troubled environment, characterized by a variety of dramatic and challenging influences, including:

- scientific advances, such as transplantation surgery and genetic engineering, which generate major ethical considerations,
- restriction on choice of physician and laboratory services,
- the spiraling increase in health care costs,
- the rationing of medical services,
- increasing and varied examples of entrepreneurs in medicine,
- widespread advertising by physicians,
- direct-to-consumer advertising by pharmaceutical companies,
- “turf” battles among medical specialties,
- a burgeoning medical malpractice problem,
- an increased number of governmental regulations that influence medical practice and patient care,
- the emergence of prepaid plans altering the traditional fee for service system of compensation for health care providers,
- the abortion controversy,
- the graying of America, and
- the moral dilemma posed by euthanasia and patient assisted suicide.

Re-examination and reiteration of the principles of medical ethics are inevitable, indeed essential, in such a dynamic societal state.

Simply put, physicians should treat patients as they would want themselves and their families to be treated, with due regard for the patient’s well-being, personal dignity, privacy and psychological and financial welfare. In addition, the relationship of physicians to their community, government and industry, especially the pharmaceutical industry, and to other physicians should withstand the careful scrutiny of fellow professionals and the laity.
If these simple maxims were routinely observed by physicians in their care of patients and in all else they do professionally, the enunciation of ethical principles in medicine would be little more than an academic exercise. However, given the wide range and complexity of medical practice issues, we need to state in a more specific and complete fashion the ethical guidelines that apply to the practice of dermatology. In doing so, it was deemed wise to begin by restating the principles of medical ethics of the American Medical Association, which represent the basic rules of professional morality under which all physicians, regardless of specialty, should function. Originally promulgated as a code of ethics by the English physician Thomas Percival in 1803, these principles were adopted by the AMA in 1847. They have been revised several times over the years. They are intended to state standards of conduct which define the essentials of honorable conduct for the physician.

ETHICS IN MEDICAL PRACTICE INDEX

I. AAD ADMINISTRATIVE REGULATIONS
   A. Code for Interactions with Companies ................................................................. 4
   B. Code of Medical Ethics ......................................................................................... 17
   C. Disclosure of Potential Conflict of Interest ......................................................... 23
   D. Judicial Panel – Disciplinary Procedures/Actions .......................................... 27

II. AMA ETHICS STATEMENTS
   A. Principles of Ethics ............................................................................................... 33
   B. Advertising and Publicity ...................................................................................... 34
   C. Chaperones during Physical Exams ................................................................. 35
   D. Gifts to Physicians from Industry ................................................................. 35

III. AAD POSITION STATEMENTS
   A. Access to Specialty Care and Direct Access ........................................... 44
   B. Capitation’s Impact on Medical Ethics .............................................................. 45
   C. Contemporary Issues: Conflict of Interest ..................................................... 48
   D. Definitions of Cosmetic and Reconstructive Surgery .............................. 52
   E. Dispensing ............................................................................................................. 53
   F. Expert Witness ...................................................................................................... 54
   G. Isotretinoin ........................................................................................................... 55
   H. Medical Spa Standards of Practice ............................................................ 57
   I. Pathology Billing .................................................................................................. 58
   J. Patient Access to Specialty Care under Healthcare Reform ...................... 59
   K. Photographic Enhancements ............................................................................ 61
   L. Physician Financial Incentives ........................................................................... 62
   M. Practice of Dermatology: Protecting and Preserving Patient Safety and Quality Care ..................................................................................................................... 63
   N. Prescribing via the Internet ................................................................................ 65
   O. Truth in Advertising & Professional Credential Disclosures ..................... 67
I. AAD ADMINISTRATIVE REGULATIONS
CODE FOR INTERACTIONS WITH COMPANIES

I. Preamble

Medical Specialty Societies play an important role in reaching out to health professionals, patients, and other groups. Our members guide biomedical research, discover new therapies, and engage in high quality medical practice. Societies offer educational opportunities that help translate scientific and medical progress into the efficient delivery of effective medical care. Societies develop resources that guide our members in advancing medical care. Societies provide a forum for presenting new skills and scientific developments.

For-profit entities that develop, produce, market or distribute drugs, devices, services or therapies used to diagnose, treat, monitor, manage, and alleviate health conditions \(^1\), referred to in this Code as “Companies,” also strive to help patients live longer and healthier lives. Companies invest resources to bring new drugs, devices and therapies out of the laboratory and to the patient while maximizing value for shareholders.

Members and patients count on Societies to be authoritative, independent voices in the world of science and medicine. Public confidence in our objectivity is critical to carrying out our mission. We know the public relies on us to minimize actual and perceived conflicts of interest. The Council of Medical Specialty Societies (CMSS) believes every Society must be sure its interactions with Companies meet high ethical standards.\(^2\)

Societies’ interactions with Companies may include receiving charitable contributions, applying for grants in support of programmatic activities, and conducting a range of business transactions.\(^3\) In all of these interactions, Societies are committed to acting with integrity and transparency.

We adopt this Code to reinforce the core principles that help us maintain actual and perceived independence. Adopting this Code helps to ensure that a Society’s interactions with Companies will be for the benefit of patients and members and for the improvement of care in our respective specialty fields.

II. About the Code

The Council of Medical Specialty Societies is a 501(c)(3) non-profit organization committed to education, professionalism and quality of care.\(^4\) In Spring 2009, at the request of the CEOs of the CMSS member organizations, the CMSS Board of Directors charged the CMSS Task Force on Professionalism and Conflicts of Interest (“Task Force”) with developing and recommending a voluntary “code of conduct” for Medical Specialty Societies to “enhance professionalism and to disclose, manage, and resolve conflicts of interest.”

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3 This Code does not address a Society’s interactions with non-profit entities or entities outside of the healthcare sector.
4 The following organizations are CMSS Member Societies American Academy of Allergy, Asthma & Immunology (AAAAI); American Academy of Dermatology (AAD); American Academy of Family Physicians (AAFP); American Academy of Hospice and Palliative Medicine (AAHPM); American Academy of Neurology (AAN); American Academy of Ophthalmology (AAO); American Academy of Otolaryngology-Head and Neck Surgery (AAOHNS); American Academy of Pediatrics (AAP); American Academy of Physical Medicine & Rehabilitation (AAPMR); American College of Cardiology (ACC); American College of Chest Physicians (ACCP); American College of Emergency Physicians (ACEP); American College of Medical Genetics (ACMG); American College of Obstetricians & Gynecologists (ACOG); American College of Occupational and Environmental Medicine (ACOEM); American College of Physicians (ACP); American College of Preventive Medicine (ACPM); American College of Radiology (ACR); American College of Rheumatology (ACR); American College of Surgeons (ACS); American Geriatrics Society (AGS); American Medical Informatics Association (AMIA); American Psychiatric Association (APA); American Society for Clinical Pathology (ASCP); American Society for Reproductive Medicine (ASRM); American Society for Radiation Oncology (ASTRO); American Society of Clinical Oncology (ASCO); American Society of Colon and Rectal Surgeons (ASCRS); American Society of Hematology (ASH); American Society of Plastic Surgeons (ASPS); American Urological Association (AUA); North American Spine Society (NASS); Society of Critical Care Medicine (SCCM); Society of Hospital Medicine (SHM); Society of Neurological Surgeons (SNS); Society of Nuclear Medicine (SNM); Society of Thoracic Surgeons (STS).
resolve relationships with industry.” For nearly one year, Task Force representatives from more than 30 Member Organizations worked collaboratively to draft a document in response to this charge. In the Spring of 2010, the Task Force recommended the CMSS Code for Interactions with Companies to the CMSS Council for adoption. The Code was officially adopted by CMSS on April 17, 2010. Modest revisions to the Code were adopted by CMSS on March 19, 2011.

The purpose of the Code is to guide Societies in the development of policies and procedures that safeguard the independence of their programs, policies, and advocacy positions. Because Societies can vary in their activities and corporate structures, these policies and procedures need not be uniform. Each Society that chooses to sign on to the Code is encouraged to adopt policies and procedures that are tailored to meet its individual organizational needs. Societies may choose to adopt policies that are more rigorous than the Code.

The Code is divided into Principles and Annotations. The Principles state what is expected of Societies that sign on to the Code. The Principles are expected to remain relatively constant, and may be changed only by the CMSS Board of Directors. The Annotations, on the other hand, reflect CMSS’ current interpretation of a given Principle. An Annotation may explain the purpose of a Principle, or give examples of Society policies and safeguards that are consistent with the Code. Annotations may be clarified periodically by CMSS in response to questions or to changes in the landscape of Society-Company interactions.

III. Definitions

The following terms are defined for purposes of this Code. CMSS recognizes that some of these terms may be used or defined differently by individual Societies or outside groups. Some of these terms refer to types of interactions in which Societies may engage with non-profit organizations and individuals as well as with Companies. They are defined here in terms of for profit Companies in order to create a common vocabulary for the Principles under this Code.

Advertising: Advertising is a Business Transaction in which a Company pays a fee to a Society in exchange for the Society’s publication of a promotional announcement that highlights the Company or the Company’s products or services. For purposes of this Code, Advertiser refers to a Company that purchases Advertising.

Business Transaction: A Business Transaction is an interaction between a Society and a Company in which a Company pays a fee to the Society in exchange for the Society’s item, service, or product. Examples of Business Transactions include Company payment of fees associated with subscriptions to Society publications, Advertising in Society publications, registrations for Society meetings, and exhibit space rental.

Charitable Contribution: A Charitable Contribution is a gift, including an in-kind gift, given by a Company to a qualified tax-exempt organization (e.g., a Society or its affiliated Foundation) for use in furthering the organization’s charitable purposes and in accordance with applicable tax rules and legal standards.

Clinical Practice Guideline: A Clinical Practice Guideline (or Guideline) is a systematically developed statement to assist practitioner and patient decisions about appropriate healthcare for specific clinical circumstances. As used in this Code, the term Clinical Practice Guideline also refers to medical technology assessments, clinical opinions, and other evidence-based clinical practice tools, as well as updates to existing Clinical Practice Guidelines (“Guideline Updates”). Societies will determine whether Clinical Practice Guidelines applies to clinical performance measurers and safety standards developed by the Society.

**Company:** A Company is a for-profit entity that develops, produces, markets, or distributes drugs, devices, services or therapies used to diagnose, treat, monitor, manage, and alleviate health conditions. This definition is not intended to include non-profit entities, entities outside of the healthcare sector, or entities through which physicians provide clinical services directly to patients. However, a Society may choose to adopt a broader definition of “Company” if doing so would better address the Society’s interactions.

**Continuing Medical Education (CME):** (CME) consists of educational activities for which the learner may receive CME credit (e.g., American Medical Association (AMA) Physician’s Recognition Award Credit, American Academy of Family Physicians (AAFP) Prescribed or Elective Credit, American Osteopathic Association (AOA) Credit – various categories) based on accreditation awarded to the continuing education provider by a recognized accrediting body (e.g., Accreditation Council for Continuing Medical Education (ACCME), AOA, AAFP). CME activities “serve to maintain, develop, or increase the knowledge, skills, and professional performance and relationships that a physician uses to provide services for patients, the public, or the profession.” For purposes of this Code, educational activities for physicians and other health care providers that are not CME-accredited are considered Non-CME Educational/Informational Programs.

**Corporate Sponsorship:** A Corporate Sponsorship is an arrangement in which a Company, typically through its marketing department, provides monetary or in-kind support for a particular Society product, service, or event, and is then acknowledged in connection with the product, service or event. Corporate Sponsorships are distinct from Educational Grants, and do not constitute Commercial Support of CME. For purposes of this Code, Corporate Sponsor refers to a Company that provides a Corporate Sponsorship.

**Direct Financial Relationship:** A Direct Financial Relationship is a relationship held by an individual that results in wages, consulting fees, honoraria, or other compensation (in cash, in stock options, or in kind), whether paid to the individual or to another entity at the direction of the individual, for the individual’s services or expertise. As used in this Code, the term Direct Financial Relationship does not mean stock ownership or intellectual property licensing arrangements. See Principle 1.4 for additional clarification of the meaning of Direct Financial Relationship.

**Educational Grant:** An Educational Grant is a sum awarded by a Company, typically through its grants office, for the specific purpose of supporting an educational or scientific activity offered by the Society. Educational Grants awarded by a Company to support a CME activity are referred to in the ACCME Standards for Commercial Support as “Commercial Support” of CME. An Educational Grant may also be “in-kind.”

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8 A Direct Financial Relationship is a compensated relationship held by an individual that should generate an IRS Form W-2, 1099 or equivalent income report. Key Society Leaders (including the President, President-Elect, Immediate Past President, the Secretary-Treasurer, Assistant Secretary-Treasurer, the chief executive officer of a Society’s membership organization, and the Editor(s)-in-Chief of Society Journal(s) may provide uncompensated service to for-profit health care products companies (“Companies”) and accept reasonable travel reimbursement in connection with those services. Key Society Leaders may accept research support as long as grant money is paid to the institution (e.g., academic medical center) or practice where the research is conducted, not to the individual.

Key Society Leaders: At a minimum, and for purposes of this Code, the Key Society Leaders are officers at the Presidential-level (e.g., the President, the President Elect, and the Immediate Past President as applicable), the Secretary-Treasurer level (e.g., Secretary-Treasurer and Assistant Secretary-Treasurer), the chief executive officer of a Society’s membership organization, and the Editor(s) in Chief of Society Journal(s).10

Medical Specialty Society: A Medical Specialty Society (or Society) is a non-profit organization whose membership includes predominantly physicians who practice in a specific medical specialty or sub-specialty that seeks to further the medical specialty, to advance the interests and education of individuals engaged in the specialty, to improve patient care, and to provide information for patients and the general public. Societies may have different corporate structures and encompass several affiliated legal entities. If a function described in the Code is carried out by an entity other than a Society’s membership organization (e.g., by an affiliated Foundation), Code provisions dealing with that function apply to the other entity to the extent the membership organization controls that entity. Each Society should decide independently how best to comply with the Code in light of its corporate structure.

Non-CME Informational/Educational Program: A Non-CME Informational/Educational Program is a program offered by a Society, Company or other third party that provides educational or promotional information and does not offer CME credit.

Research Grant: A Research Grant is an award that is given by a Society to an individual, institution, or practice to fund the conduct of scientific research. Companies may provide Societies with programmatic support (e.g., an Educational Grant or Charitable Contribution) designated for the specific purpose of funding Research Grants.

Satellite CME Symposium: A Satellite CME Symposium is a Company-supported CME program held as an adjunct to a Society meeting where CME credit for the Symposium is provided by a third party CME provider, and for which the Society receives a fee.

Society CME: Society CME refers to CME programs that are planned by a Society and for which the Society, as an accredited CME provider, provides CME credit.

Society Journal: A Society Journal is a peer-reviewed scientific journal published by a Society or by a publisher on a Society’s behalf.

IV. Principles for Interaction

1. Independence

1.1. Societies will commit that their educational activities, scientific programs, products, services and advocacy positions are independent of Company influence, and will develop and adopt policies and procedures that foster independence.

Annotation: These policies need not be uniform; rather, each Society’s policies can be tailored to fit its individual organizational needs. Societies should make these policies available to the public (See Principle 2).

If a Society collaborates with a Company on a project or utilizes a Company’s product or service, there will be an arms-length business relationship between the Society and the Company. The Society will apply its independent judgment to the arrangement and will not allow the Company to control content or project decisions.

1.2. Societies will separate their efforts to seek Educational Grants, Corporate Sponsorships, Charitable Contributions, and support for Research Grants from their programmatic decisions.

Annotation: The initial step in program development is the independent assessment by a Society that a program is needed (e.g., to address gaps in care or knowledge). Once a Society determines that a program is needed, it is permissible to assess the availability of funds.

10 See definition of Society Journal
1.3. Societies will identify the high-level group responsible for guiding Society interactions with Companies.

Annotation: A Society may assign the responsibility of monitoring and guiding Society-level interactions with companies to an existing group, such as its Board of Directors (or a subcommittee of the Board), Ethics Committee, or Conflict of Interest Committee, or to a new group created for this purpose.

1.4. No Key Society Leader, defined for purposes of this Code as the Presidential-level of a Society’s membership organization (e.g., the President, President-Elect, and Immediate Past President as applicable), the Secretary-Treasurer level (e.g., Secretary-Treasurer and Assistant Secretary-Treasurer) the chief executive officer of a Society’s membership organization, and the Editor(s)-in-Chief of Society Journal(s), may have Direct Financial Relationships with Companies during his or her term of service.

With the Academy’s adoption of the Code for Interactions with Companies, the successful officer candidates will be required to divest themselves during their entire term in office of any direct financial relationships with for-profit companies that manufacture or sell health care products or services.

Annotation: Each Society may set a reasonable period after election or appointment for Key Society Leaders to terminate any Direct Financial Relationships. A Society may permit Key Society Leaders who are elected or appointed prior to the time the Society signs on to the Code to maintain existing Direct Financial Relationships with Companies for the duration of their terms. These relationships should be disclosed and managed in accordance with Principles 23 and 24.

Under Principle 1.4, a Key Society Leader may provide uncompensated service to Companies and accept reasonable travel reimbursement in connection with those services. A Key Society Leader may accept research support as long as grant money is paid to the institution (e.g., academic medical center) or practice where the research is conducted, not to the individual. A Key Society Leader may receive wages or other compensation from a Company in exchange for providing or overseeing the provision of health services to Company personnel. A Key Society Leader may accept reasonable compensation for serving on an independent data safety monitoring board in a Company study. A Key Society Leader may own stock or stock options in a Company. A Key Society Leader may receive royalties or similar fees relating to patents or other intellectual property. While permitted under Principle 1.4, all such relationships should nevertheless be disclosed and managed in accordance with Principles 23 and 24.

If a Key Society Leader receives stock or stock options from a Company as wages, consulting fees, honoraria, or other compensation (other than permitted payments as described in the prior paragraph), this is considered a Direct Financial Relationship. If a Key Society Leader directs a Company honorarium or other fee to the Society, a charity, or another entity, this is considered a Direct Financial Relationship. See the definition of “Direct Financial Relationship” for additional information relating to Principle 1.4. See Principles 5.25 and 5.4.4 for additional limitations on the relationships of Key Society Leaders.

1.5. Societies will use written agreements with Companies for Educational Grants, Corporate Sponsorships, Charitable Contributions, Business Transactions, and support of Research Grants.

Annotation: Good business practices require that funds accepted from Companies be associated with written agreements that specify what the funds are for, the amount given, and the separate roles of the Company and the Society. Such agreements show that a transaction is “arm’s length,” establish clear parameters for the use of funds, and affirm the independence of the Society. To help Societies comply with this Principle, CMSS will develop customizable agreement templates or standard clauses to serve as a model for Societies’ written agreements. Societies may choose to use these templates or create their own agreements independently.

2. Transparency

2.1. Societies will make their conflict of interest policies and/or forms available to their members and the public.
Annotation: Transparency is a key element in fostering confidence in Societies’ independence. Societies should make disclosure forms and policies adopted under Principle 1.1 of this Code available to the public. Societies may choose to make internal conflict of interest management procedures publicly available as well.

2.2. Societies will disclose Company support (at a minimum Educational Grants, Corporate Sponsorships, Charitable Contributions, and support of Research Grants), making this information available to their members and the public.

Annotation: With the support of CMSS, Societies will work together, along with other appropriate stakeholders, to develop a consistent template for disclosure of Company support received by a Society. Generally, disclosure fields should include the name of the Company, the category of support (e.g., Educational Grant, Corporate Sponsorship, Charitable Contribution), the time period of the support, and the dollar amount or range. Some Societies may also decide to disclose information related to Business Transactions, support from donors outside of the for-profit healthcare sector, support from non-profit organizations, and support from individual donors.

2.3. Societies will adopt written disclosure policies for Key Society Leaders, Board members, committee members and others who serve on behalf of the Society, and will use the disclosed information to manage conflicts of interest in decision making. Societies will require volunteers to update disclosure information at least annually and when material changes occur.

CMSS will support and participate in efforts to arrive at a consistent scope and format for individual disclosure across multiple organizations and activities.

Societies can manage conflicts of interest in a variety of ways. In some cases, disclosure is sufficient. Additional conflict of interest management mechanisms such as recusal, peer review, and CME session audits may be appropriate. Societies should select conflict of interest management mechanisms that are appropriate for the activity and type of relationship under consideration.

2.4. Societies will disclose all financial and uncompensated relationships that Key Society Leaders and members of the Board of Directors of the Society’s membership organization have with Companies, making this information available to their members and the public.

Annotation: With the support of CMSS, Societies will work together, along with other appropriate stakeholders, to develop a consistent template for disclosure of these relationships. Generally, disclosure fields should include employment, consulting or advisory arrangements, stock ownership, honoraria, research funding paid to an individual’s institution or practice, expert testimony, and gifts.

A Society is not required to disclose the relationships of Board members elected prior to the time the Society signs on to the Code.

3. Accepting Charitable Contributions

3.1. Societies will control the use of Charitable Contributions in a manner that is aligned with the Society’s strategic plan and mission.¹¹

3.2. Societies will decline Charitable Contributions where the Company expects to influence Society programs or advocacy positions, or where Company restrictions would influence Society programs or advocacy positions in a manner that is not aligned with the Society’s mission.

3.3. Societies will adhere to applicable tax rules and legal standards for acceptance of Charitable Contributions and management of institutional funds.

3.4. Reasonable restrictions on the purposes for which Charitable Contributions will be used are acceptable, as are reasonable requirements for reporting on the uses of the donated funds.

¹¹ See Definition of Society for discussion of the role of affiliated foundations.
3.5. Societies will adopt policies for consistent and appropriate recognition of donors.

4. Accepting Corporate Sponsorships

4.1. Societies will only accept Corporate Sponsorship of an item or program if the item or program is aligned with the Society’s strategic plan and mission.

4.2. Societies will make reasonable efforts to seek multiple Corporate Sponsors for sponsored items or programs.

5. Society Meetings

5.1. Society Educational and Informational Programs

5.1.1. When providing Society CME, Societies will comply with ACCME Standards for Commercial Support, including by adopting policies and procedures designed to identify and manage conflicts of interest in Company-supported Society CME programs.

Annotation: Societies should adopt policies and procedures for managing the relationships of individuals who plan, carry out, or contribute to the content of Society CME activities. Adopting and rigorously enforcing these policies precludes Company influence over Society CME content.

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5.1.2 In providing Society CME, Societies will not seek support for product-specific topics.

Annotation: Where the purpose of a Society CME session is to demonstrate or train learners in the safe and effective use of a particular drug, device, service or therapy, Societies may accept in-kind support from Companies that develop, produce, market, or distribute that drug, device, service or therapy. In accordance with ACCME Standards, a Society may accept in-kind support from a single Company when other equal by competing products or services are not available for inclusion.

5.1.3 Societies will make reasonable efforts to achieve a balanced portfolio of support for each Society CME program.

Annotation: Societies will make reasonable efforts to seek multiple sources of support for Society CME programs, including support from Companies, support from organizations outside the for-profit healthcare sector, and tuition from learners.

5.1.4. Societies will retain control over the use of Educational Grants and implement safeguards designed to ensure that educational programs are non-promotional and free from commercial influence and bias.

5.1.5. Societies will appoint their own planning committees to select the objectives, content, faculty, and format of educational activities in a manner that is consistent with their organizational missions.

5.1.6. Societies will not solicit supporters’ suggestions about program topics, speakers, or content.

Annotation: This restriction would not prevent Societies from assessing the availability of funds for a program in accordance with Principle 1.2.

5.1.7. Societies will prohibit presenters from using Company-controlled presentation materials, and from using slides with Company logos.

5.1.8. Societies will require presenters in Society CME programs to give a balanced view of therapeutic options, and will encourage presenters to use generic names in place of product trade names.

5.1.9. Societies will clearly distinguish their Non-CME Informational/Educational Programs from Society CME.

5.2. CME Accredited Satellite Symposia

5.2.1. Societies will require Satellite CME Symposia to undergo an application and selection process.

5.2.2. Societies will require Satellite CME Symposia to comply with ACCME Standards.

Annotation: Societies can best implement Principle 5.2.2 by requiring written agreements with third party CME providers. Written agreements should also include consequences for non-compliance.

To minimize the potential for bias in Satellite CME Symposia, Societies may also consider the following best practices:

1. Requiring presentations to be evidence-based;
2. Requiring peer review of slide presentations in advance;
3. Prohibiting presenters who disclose unmanageable conflicts from making practice recommendations. These presenters may present on general topics only (e.g., pathophysiology, research data). An additional speaker without unmanageable conflicts may be added to the program to make practice recommendations instead.
4. Requiring presentations to be monitored by reviewers trained to recognize bias.

13 See Definition of Satellite CME Symposium. Based on the definition of Satellite CME Symposium, Section 5.2 of the Code does not apply to programs that are held adjunct to Society meetings but (1) are not Company supported; (2) are not CME accredited; or (3) for which Societies do not receive a fee.
5.2.3. Societies will ensure that Satellite CME Symposia are clearly distinguished from Society CME in Society meeting programs and promotional materials.

5.2.4. Societies will require third party organizers of Satellite CME Symposia to use appropriate disclaimers to distinguish the Symposia from Society CME programs in Symposia advertising and program materials.

5.2.5. Societies will not permit Key Society Leaders to participate in Satellite CME Symposia as faculty members, presenters, chairs, consultants, or in any other role besides that of a learner who receives no honoraria or reimbursement.

Annotation: See Principle 1.4 for additional limitations on the relationships of Key Society Leaders.

5.3. Company Informational/Educational Programs

5.3.1. Societies will require Company Informational/Educational Programs to be clearly distinguished from CME.

Annotation: Through the Company’s use of appropriate disclaimers in advertising and informational materials, learners of Non-CME Informational/Educational Programs should be able to easily ascertain that the Programs are not CME accredited.

5.4. Exhibits

5.4.1. Societies will adopt written policies that govern the nature of exhibits and the conduct of exhibitors, including by requiring exhibitors to comply with applicable laws, regulations, and guidance.

Annotation: Society policies can place limits on exhibits and exhibitor conduct (e.g., booth décor, size, and activities) to ensure that the tone of the exhibit hall is professional in nature. Policies should be provided to exhibitors and made available to others upon request.

5.4.2. Societies will only permit exhibitor giveaways that are educational and modest in value.

Annotation: The requirement that Company giveaways be educational (for physicians or patients) and modest in value originates in the standards for ethical interactions set out by AMA, PhRMA, and AdvaMed. The educational giveaway requirement stated in Principle 5.4.2 applies equally to Companies that have signed on to the PhRMA or AdvaMed Codes and those that have not. This approach allows Societies to place all Company exhibitors on an even playing field. Principle 5.4.2 does not apply to non-profit exhibitors or to exhibitors outside of the healthcare sector. However, Societies may apply these requirements more broadly at their individual discretion.

5.4.3. Societies will make reasonable efforts to place exhibit booths out of learners’ obligate path to Society CME sessions.

5.4.4. Key Society Leaders may not participate as leaders or presenters in Company promotional/marketing events held in exhibit space.

Annotation: Participation of Key Society Leaders in Company promotional or marketing events has the potential to create the perception that the Society endorses a particular Company or product. In order to avoid this perception, Societies should prohibit Key Society Leaders from participating as leaders or presenters, and may consider extending this restriction to the entire Board of Directors. See Principle 1.4 for additional limitations on the relationships of Key Society Leaders.

6. Awarding of Research Grants

6.1. Societies will not permit Companies to select (or influence the selection of) recipients of Research Grants.

6.2. Societies will appoint independent committees to select recipients of Research Grants based on peer review of grant applications.
6.3. Societies will not require recipients of Research Grants to meet with Company supporters. 

Annotation: An individual, institution or practice that receives a Research Grant may publicly acknowledge the Company that supported his or her Research Grant, if known. Research Grant recipients may be required to disclose known Company support in connection with the presentation or publication of grant-funded research.

6.4. Societies will not permit Companies that support Research Grants to receive intellectual property rights or royalties arising out of the grant-funded research.

6.5. Societies will not permit Companies that support Research Grants to control or influence manuscripts that arise from the grant-funded research.

6.6. If a Society receives programmatic support (e.g., an Educational Grant or Charitable Contribution) from a Company to support the Society's own research, the Society will disclose the Company support. The Society will act independently in the selection of research topics and the conduct of the research itself.

7. Clinical Practice Guidelines

7.1. Societies will base Clinical Practice Guidelines on scientific evidence.

Annotation: Many Societies develop and publish Clinical Practice Guidelines, medical technology assessments, and other clinical practice opinions in order to meet their members' needs for tools that help improve the quality and effectiveness of patient care. The credibility and authority of Society Guidelines depends on a common understanding that Guidelines are developed through a rigorous independent process, based on the best available scientific evidence. Societies may refer to published criteria for rating studies and other evidence, or may use another recognized means of characterizing the strength of medical evidence.

The definition of Clinical Practice Guidelines in this Code includes “other clinical practice tools.” Some Societies develop and publish measures or standards for quality, safety, or other types of performance. Performance measures may apply to clinical care, research or other professional activities. To underscore the credibility of its performance measures, a Society may choose to treat them as Clinical Practice Guidelines for purposes of this Code, applying the standards for independence and transparency set out in this Principle 7.

7.2. Societies will follow a transparent Guideline development process that is not subject to Company influence. For Guidelines and Guideline Updates published after adoption of the Code, Societies will publish a description of their Guideline development process, including their process for identifying and managing conflicts of interest, in Society Journals or on Society websites.

Annotation: Healthcare providers, payors, and patients regard Society Clinical Practice Guidelines as an important source of information from experts in the field. Societies must therefore take steps to ensure that Guidelines are free from commercial bias and Company influence.

7.3. Societies will not permit direct Company support of the development of Clinical Practice Guidelines or Guideline Updates.

Annotation: Societies will not accept Corporate Sponsorship, Educational Grants, Charitable Contributions, support of Research Grants, or any other direct Company support of Guideline development activities. Company support of the overall mission based activities of a Society is not considered direct support of Guideline development.

7.4. Societies will not permit direct Company support for the initial printing, publication, and distribution of Clinical Practice Guidelines or Guideline Updates. After initial development, printing, publication and distribution is complete, it is permissible for Societies to accept Company support for the Society's further distribution of the Guideline or Guideline Update, translation of the Guideline or Guideline Update, or repurposing of the Guideline content.
Ethics in Medical Practice

Annotation: After initial development, printing, publication, and distribution of a Guideline or Guideline Update is complete, it is permissible for a Society to engage in Business Transactions where Companies purchase Guideline reprints or license Guideline content for translation or repurposing. A Society may choose to require a written statement with the purchased or licensed material, acknowledging the Company’s role and describing the independent nature of the Society’s Guideline development process.

7.5. Societies will require all Guideline development panel members to disclose relevant relationships prior to panel deliberations, and to update their disclosure throughout the Guideline development process.

7.6. Societies will develop procedures for determining whether financial or other relationships between Guideline development panel members and Companies constitute conflicts of interest relevant to the subject matter of the guideline, as well as management strategies that minimize the risk of actual and perceived bias if panel members do have conflicts.

Annotation: For example, Societies may decide not to permit panel members with conflicts of interest to draft text or vote on panel recommendations.

7.7. Societies will require that a majority of Guideline development panel members are free of conflicts of interest relevant to the subject matter of the Guideline.

Annotation: If Guideline development panel members and chairs (see Principle 7.8) have conflicts of interest at the time of adoption of the Code, a Society may permit these individuals to remain actively involved in drafting the Guideline. However, each panel for which this exception is made must meet the requirements of Principle 7.7 by the time of the next Guideline Update. For the minority of panel members who are not free of conflicts, Societies will apply procedures for disclosure and conflict of interest management developed in accordance with Principles 7.5 and 7.6.

7.8. Societies will require the panel chair (or at least one chair if there are co-chairs) to be free of conflicts of interest relevant to the subject matter of the Guideline, and to remain free of such conflicts of interest for at least one year after Guideline publication.

Annotation: In addition to minimizing potential conflicts, remaining free of conflicts of interest helps to ensure that a panel chair remains eligible to participate in subsequent Guideline Updates.

7.9. Societies will require that Guideline recommendations be subject to multiple levels of review, including rigorous peer-review by a range of experts. Societies will not select as reviewers individuals employed by or engaged to represent a Company.14

Annotation: As part of their published Guideline development processes, Societies will seek critical feedback on draft Guidelines from independent reviewers. These may include subject matter experts, healthcare practitioners, biostatisticians, and patient representatives, among others.

7.10. Societies' Guideline recommendations will be reviewed and approved before submission for publication by at least one Society body beyond the Guideline development panel, such as a committee or the Board of Directors.

7.11. Guideline manuscripts will be subject to independent editorial review by a journal or other publication where they are first published.

Annotation: Editorial review provides an additional safeguard independent of a Society’s Guideline development and approval process.

7.12. Societies will publish Guideline development panel members’ disclosure information in connection with each Guideline and may choose to identify abstentions from voting.

7.13. Societies will require all Guideline contributors, including expert advisors or reviewers who are not officially part of a Guideline development panel, to disclose financial or other substantive relationships that may constitute conflicts of interest.

Annotation: To identify and manage conflicts of interest among contributors, advisors, and reviewers, Societies should follow similar procedures as those applied to the Guideline development panel. Societies collaborating with or seeking input from outside organizations on guideline development should investigate the conflict of interest standards of those organizations.

7.14. Societies will recommend that Guideline development panel members decline offers from affected Companies to speak about the Guideline on behalf of the Company for a reasonable period after publication.

Annotation: A period of at least one year is recommended. An affected company is one that is reasonably likely to be positively or negatively affected by care delivered in accordance with the Guideline.

7.15. Societies will not permit Guideline development panel members or staff to discuss a Guideline’s development with Company employees or representatives, will not accept unpublished data from Companies, and will not permit Companies to review Guidelines in draft form.

8. Society Journals

8.1. A Society Journal will maintain editorial independence from the Society and from Advertisers.

Annotation: In general, a firewall separates the editorial decisions of a Society Journal from Society governance and operations. Editorial independence should be consistent with accepted standards for medical publishing such as those established by the International Committee of Medical Journal Editors (ICMJE) and the World Association of Medical Editors (WAME).

8.2. Society Journals will require all authors to disclose financial and other relationships with Companies.

Annotation: Authors’ disclosure information will be considered by Society Journal editors in evaluating an article for publication. If the article is published, Society Journals will publish the authors’ disclosure information with the article or issue. The “look-back” period for disclosure should be at least one year. Society Journals will adopt policies governing the scope and format of disclosure, including consistent disclosure categories.

8.3. Society Journals will require editors and reviewers to disclose financial and other relationships with Companies.

Annotation: Each Society Journal will publish its editors’ disclosure information on its website.

8.4. The Editor-in-Chief of each Society Journal will have the ultimate responsibility for determining when a conflict of interest should disqualify an editor or reviewer from reviewing a manuscript, according to established policies.

Annotation: When establishing these policies, Society Journals may find it helpful to consult accepted standards for medical publishing such as those established by ICMJE and WAME.


8.5. Society Journals will adopt policies prohibiting the submission of “ghost-written” manuscripts prepared by or on behalf of Companies.

9. **Standards for Advertising**

9.1. Societies will adopt written policies that set standards for Advertising.

*Annotation: Advertising in all Society publications should be easily distinguishable from editorial content (e.g., through labels and color-coding). Advertising should not be designed to look like scientific articles. In Society Journals, the placement of Advertising adjacent to articles or editorial content discussing the Company or product that is the subject of the ad should be prohibited. Advertising in Society Journals should subject to review by the Editor-in-Chief and overseen by the Society. Society Journals and other Society publications that publish Advertising for CME activities or provide activities through which readers can earn CME credits should also comply with ACCME requirements for Advertising set out in the Standards for Commercial Support.***

10. **Standards for Licensing**

10.1. Societies will adopt written standards for licensing that are intended to prevent misuse, unintended use, and modification of licensed materials, prohibit modification of licensed materials in a way that would change their meaning, and prohibit use of Society trademarks to imply Society endorsement of Company products or services.

V. **Adherence to the Code**

Signing on to this Code is voluntary and is not a condition of continued membership in CMSS. Societies that sign on to the Code will be identified on the CMSS website. Societies that are not members of CMSS may also sign on to the Code, and will be listed on the CMSS website as well.

Societies that sign on to the Code should adopt policies and procedures to guide Society-Company interactions in accordance with the Code. Societies will interpret and implement the Code in the context of their organizational structure and their policies and procedures.

Societies that sign on to the Code are encouraged to comply with as many Principles as possible at the time they sign on, and should set a reasonable timeframe for adopting the policies and procedures required to comply with any remaining Principles. At their individual discretion, Societies may choose to adopt policies that are more rigorous than the Code.

Societies should regularly evaluate their success in adhering to the Code. Societies will be encouraged to affirm annually to CMSS that they continue to adhere to the Code. Societies that affirm that they adhere to the Code will continue to be identified on the CMSS website. Any comments received by CMSS relating to a Society’s adherence to the Code will be referred to the Society.

*Approved: Board of Directors: 5/22/10; revised: 2/05/11; 8/06/11*
CODE OF MEDICAL ETHICS FOR DERMATOLOGISTS

PREAMBLE

Concerns for the patient's welfare and the appropriate behavior of the physician are a part of the heritage of medicine originating with the Code of Hammurabi, a code of ethics dating from 2000 BC. Guidelines for ethical behavior must address the demands of a contemporary dermatologic practice. The American Academy of Dermatology (Academy) developed The Code of Medical Ethics for Dermatologists ("The Code") primarily for the benefit of our patients. The Code reminds members of their ethical obligations, provides standards and guidelines for their adherence, and demonstrates to the broader community the commitment of the Academy and its members to high ethical standards. This document is, in part, derived from the Principles of Medical Ethics and Current Opinions of the Council on Ethical and Judicial Affairs of the American Medical Association (AMA). Since the AMA document is necessarily broad, the Academy Code is directed to concerns of specific interest to dermatologists. Dermatologists are encouraged to refer to the Current Opinions of the Council on Ethical and Judicial Affairs of the AMA for guidance if the particular ethical matter at issue is not addressed in the Academy's Code of Medical Ethics for Dermatologists.

The Academy's Code provides standards of conduct that define the essentials of honorable behavior for the Dermatologist. The Code, while taking into account the legal requirements of medical practice, calls for and espouses a standard of behavior that is, in some cases, higher than that required by the law.

Dermatologists should recognize that they are role models for dermatologists-in-training and other health care professionals and should by their deeds and actions comply with the Academy's Code of Medical Ethics for Dermatologists. Violations may be subject to disciplinary action pursuant to the procedures set forth in the Academy's Administrative Regulations.

While the Academy's Code clearly applies to its Dermatologist members, any provision that is not uniquely applicable to the practice of dermatology shall also apply to the Academy's non-physician and non-dermatologist members. For instance, the Code is generally applicable to non-dermatologist physician members, as well as non-physician members, to the extent that they treat patients; engage in research; publish scholarly articles; or interact with other health care professionals, industry, the public, or the media. The Academy, acting through its officers, directors, and Ethics Committee, will apply commonsense and fairness in determining whether specific provisions of the Code are applicable to non-Dermatologist members. Where the Academy determines that the applicability of a particular provision of the Code to non-Dermatologists is unclear, the Academy will provide members who are found to have violated such provision with a warning or letter of concern rather than taking disciplinary action. After receiving such letter, a non-Dermatologist member who is found to have engaged in the same or similar misconduct again will be subject to disciplinary action.

I. The Physician-Patient Relationship

A. The dermatology profession exists for the primary purpose of caring for the patient. The physician-patient relationship is the central focus of all ethical concerns. Dermatologists should be dedicated to providing medically competent service with compassion and respect for human dignity. Abuse of the physician's dominant position to take advantage of a patient sexually is both unethical and reprehensible and may lead to loss of medical licensure. Exploitation of patients by physicians in financial or business matters is similarly offensive and unethical.

B. The physician-patient relationship has a contractual basis and is based on confidentiality, trust, and honesty. Dermatologists should respect the rights of their patients and must

17 References to “Dermatologists” in this Code of Ethics apply to all members of the American Academy of Dermatology except Adjunct or Corporate Members and Honorary Members or Life Members who were Adjunct Members and are not eligible under any other membership categories.
safeguard patient privacy within the constraints of the law. Both the patient and the dermatologist are free to enter or discontinue the relationship within any existing constraints of a contract with a third party. A dermatologist has an obligation to render care only for those conditions that he or she is competent to treat. The dermatologist shall not decline to accept patients solely on the basis of race, color, gender, sexual orientation, religion, or national origin or on any basis that would constitute illegal discrimination. It is also unethical for a dermatologist to discriminate against a class or category of patients and to refuse the management of a patient because of medical risk, real or imagined. In relation to such patients, therefore, physicians and other health care personnel are expected to provide the same compassionate and competent management given to other patients.

C. The dermatologist may choose whom he or she will serve. However, the dermatologist should not impose coercive conditions of treatment, including but not limited to requiring patients to release the dermatologist from any liability for his/her treatment of the patient or waive other basic rights, such as privacy or free speech, as a condition of treatment. A dermatologist should render services to the best of his or her ability. Having undertaken the care of a patient, the dermatologist may not neglect or abandon that person. Unless discharged by the patient, the dermatologist may discontinue service only after giving adequate notice to the patient so that the patient can secure alternative care. In an emergency, however, dermatologists should render service to the best of their ability and provide or arrange for any necessary follow-up care. Managed care agreements may contain provisions which alter the method by which patients are discharged. If the enrollment of a dermatologist or patient is discontinued in a managed care plan, the dermatologist will have a responsibility to assist the patient in obtaining follow-up care. In this instance, the dermatologist will be responsible for providing medically necessary care for the patient until appropriate referrals can be arranged.

D. Dermatologists should provide their patients a reasonable explanation of the etiology, treatment and prognosis of their disease. When obtaining informed consent for treatment, the dermatologist is obligated to present to the patient or to the person responsible for the patient, in understandable terms, pertinent medical facts and recommendations consistent with good medical practice. Such information should include alternative modes of treatment, the objectives, risk and possible complications of such treatment, and the complications and consequences of no treatment.

II. Personal Conduct

A. The dermatologist should maintain a reputation for truth and honesty. In all professional conduct, the dermatologist is expected to provide competent and compassionate patient care, exercise appropriate respect for other health care professionals, and maintain the patient's best interests as paramount.

B. The dermatologist should conduct himself or herself morally and ethically, so as to merit the confidence of patients entrusted to the dermatologist's care, rendering to each a full measure of service and devotion.

C. The dermatologist should obey all laws, uphold the dignity and honor of the profession, and accept the profession's self-imposed discipline. Academy members should also obey all Academy and American Academy of Dermatology Association Bylaws, Administrative Regulations, and Board-approved polices and may be subject to disciplinary action by the Academy and the Association for failing to do so. Within legal and other constraints, if the dermatologist has a reasonable basis for believing that a physician or other health care provider has been involved in any unethical or illegal activity, including but not limited to gross negligence or incompetence, the dermatologist is encouraged to prevent the
continuation of this activity by communicating with that person and/or identifying that person to a duly-constituted peer review authority or the appropriate regulatory agency. In addition, the dermatologist should cooperate with peer review and other authorities in their professional and legal efforts to prevent the continuation of unethical or illegal conduct. Academy members are expected to report knowledge of violations of the Bylaws, Code of Ethics, or other Administrative Regulations or Board-approved policies to the Academy. When a member is convinced that another member is violating the Bylaws, Code of Ethics, other Administrative Regulations, or Board-approved policies, the member should send a confidential written communication to the Academy’s Secretary-Treasurer or Executive Director. The information so submitted will then be further investigated and processed according to the provisions of the Bylaws and Administrative Regulations.

D. Because of the dermatologist’s responsibility for the patient’s life and future welfare, substance abuse is a special threat that must be recognized and stopped. The dermatologist must avoid substance abuse and, when necessary, seek rehabilitation. It is every physician’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, dermatologists have a collegial and a medical responsibility to encourage and assist the impaired colleague in obtaining care, even if the impaired colleague must be reported to the appropriate state authority to begin the steps toward receiving adequate care.

III. Conflicts of Interest

A. The practice of medicine inherently presents potential conflicts of interest. When a conflict of interest arises, it must be resolved in the best interest of the patient. The dermatologist should exercise all reasonable alternatives to ensure that the most appropriate care is provided to the patient. If the conflict of interest cannot be resolved, the dermatologist should notify the patient of his or her intention to withdraw from the relationship.

B. If the dermatologist has a financial or ownership interest in a durable medical goods provider, imaging center, surgery center or other health care facility where the dermatologist’s financial interest is not immediately obvious, the dermatologist must disclose this interest to the patient. The dermatologist has an obligation to know the applicable laws regarding physician ownership, compensation and control of these services and facilities.

C. When a dermatologist receives anything of significant value from industry, a potential conflict exists which should be disclosed to the patient. When a dermatologist receives inventor royalties from industry, the dermatologist should disclose this fact to the patient if such royalties relate to the patient’s treatment. It is unethical for a dermatologist to receive compensation of any kind from industry for using a particular device or medication. Reimbursement for reasonable administrative costs in conducting or participating in a scientifically sound research clinical trial is acceptable. Dermatologists should comply with the Academy’s policy on gifts to physicians as amended from time to time. The Academy endorses and expects its members to follow the American Medical Association’s Policy on Gifts to Physicians from Industry. (AMA Code of Medical Ethics, E-8.061)

D. A dermatologist reporting on clinical research or experience with a given procedure or device must disclose any financial interest in that procedure or device if the dermatologist or any institution with which that dermatologist is connected has received anything of value from its inventor or manufacturer.

E. Except when inconsistent with applicable law, dermatologists have a right to dispense medication, assistive devices, dermatologic appliances, and similar related patient-care items, and to provide facilities and render services as long as their doing so is in the best
interests of their patients and provides a convenience or an accommodation to the patient without taking financial advantage of the patient. Dermatologists should not promote, supply or dispense to their patients products which have no beneficial effect. Ultimately, the patient must have the choice of accepting the dispensed medication or patient-care items or obtaining them outside the dermatologist’s office.

IV. Maintenance of Competence
The dermatologist continually should strive to maintain, apply, and advance medical and scientific knowledge and skill; and should make available to patients, colleagues, and the public the benefits of his or her professional attainments. Each dermatologist should participate in continuing medical educational activities.

V. Relationships with Dermatologists, Nurses, and Allied Health Personnel

A. Dermatologists should uphold the honor of the profession by dealing honestly with their colleagues; dermatologists should recognize the responsibility and necessity for communication and mutual respect among dermatologists in the academic community and dermatologists in private practice.

B. Good relationship among physicians, nurses, and other health care professionals are essential for good patient care. The dermatologist should promote the development of an expert health care team that will work together harmoniously to provide optimal patient care.

C. Dermatologists should limit the source of their professional income to services actually rendered by them, or by allied health personnel acting in accordance with the AAD policy on The Use of Non-Physician Office Personnel (P-11.500).

D. The professional conduct of the dermatologist will be scrutinized by local professional associations, hospital(s), managed care organization(s), peer review committees, and state medical and/or licensing boards. These groups deserve the participation and cooperation of dermatologists.

VI. Relationship to the Public

A. Dermatologists should provide the general public information necessary or helpful to select a qualified physician. The dermatologist should not publicize himself or herself through any medium or form of public communication in an untruthful, fraudulent, misleading, or deceptive manner. Competition between and among dermatologists and other health care practitioners is ethical and acceptable. The Academy endorses and expects its members to follow the American Medical Association’s Policy on Advertising and Publicity. (AMA Code of Medical Ethics, E-5.02)

B. Professional fees should be commensurate with the services provided and dermatologists should neither pay nor receive commissions for the referral of patients. Dermatologists also should not engage in fraudulent billing or coding. For example, it is unethical for dermatologists to bill individually for services that are properly considered a part of the “global service” package where defined, i.e., services that are a necessary part of the surgical procedure. It is unethical for dermatologists to submit billing codes that reflect higher levels of service or complexity than those that were actually required. It is unethical for dermatologists to charge for services not provided.

C. Dermatologists are encouraged to devote some time and work to provide care for individuals who have no means of paying. Dermatologists also should work actively to eliminate discrimination in health care, whether based on race, gender, sexual preference, socioeconomic status, ethnicity, religion, or any other social category.
D. The dermatologist may enter into a contractual relationship with a group, managed care plan, prepaid practice plan, or hospital. The dermatologist has an obligation to serve as the patient's advocate and to ensure that the patient's welfare remains the paramount concern.

VII. General Principles of Care

A. A dermatologist should practice only within the scope of his or her personal education, training, and experience. The patient should be referred to the appropriate individuals for problems which fall outside the training and expertise of the dermatologist. Likewise, dermatologists should seek consultation upon request, in doubtful or difficult cases, or whenever it appears that the quality of medical service may be enhanced thereby.

B. Dermatologists should provide only those services which are in the patient's best interest, are medically necessary, and/or appropriate for the patient's condition. It is unethical to prescribe, provide, or seek compensation for unnecessary services, unlawful athletic enhancements, to withhold services that are medically necessary, or, in the case of cosmetic or other discretionary procedures, to provide care not requested by the patient.

C. The dermatologist should not perform a surgical operation under circumstances in which the dermatologist is not in a position to provide appropriate post-surgical care or delegate responsibility for such care to another qualified physician.

D. Patient records include privileged information. When a patient submits a proper, written request for records, the dermatologist must release the records to the patient or the patient's designee. Charges should be commensurate with the services provided and expenses incurred to reproduce and transmit the medical records and should not be contingent upon satisfaction of patient indebtedness to the physician for services rendered. Certain correspondence from insurance carriers or attorneys may call for an opinion on the part of the dermatologist. As such, a reasonable fee for professional services is permissible.

VIII. Research and Academic Responsibilities

A. All research and academic activities must be conducted under conditions of full compliance with ethical, institutional, and government guidelines. Patients participating in research programs must have given full informed consent and retain the right to withdraw from the research protocol at any time.

B. Dermatologists should not claim as their own intellectual property that which is not theirs. Plagiarism or the use of others' work without attribution is unethical.

C. The principal investigator of a scientific research project or clinical research project is responsible for proposing, designing, and reporting the research. The principal investigator may delegate portions of the work to other individuals, but this does not relieve the principal investigator of the responsibility for work conducted by the other individuals.

D. The principal investigator or senior author of a scientific report is responsible for ensuring that appropriate credit is given for contributions to the research described.

IX. Community Responsibility

A. The honored ideals of the medical profession imply that the responsibility of the dermatologist extends not only to the individual but also to society as a whole. Activities that have the purpose of improving the health and wellbeing of the patient and/or the community in a cost-effective way deserve the interest, support, and participation of the dermatologist. Appropriate publicity regarding dermatologists' participation in community and civic affairs enhances the stature of the profession. In all dealings with the press, it is
improper to use the name or corporate logo of the AAD, or to otherwise make reference to
the Academy, in a manner that would lead the reader to believe the physician to be the
official spokesperson of the Academy or to have been endorsed by the Academy unless
the individual in fact is specifically authorized to speak on behalf of the Academy. This
would be particularly true in the endorsement of a product. The unauthorized use of the
Academy name or corporate logo is forbidden. Its placement in an advertisement would
lead the reader to think the Academy endorses the physician or product.

B. Dermatologists are encouraged to participate in the education of the next generation of
dermatologists.

C. Dermatologists are called upon to provide expert medical testimony in courts of law and
administrative proceedings. Testimony in matters medical/legal is as much a part of the
practice of medicine as is caring for patients. In providing testimony, the dermatologist
should ensure that he or she is appropriately qualified and provide testimony that is unbi-
asied, scientifically correct, clinically accurate, and otherwise truthful. The dermatologist
should not testify concerning matters about which the dermatologist is not knowledge-
able. It is unethical for a dermatologist to accept compensation that is contingent upon
the outcome of litigation. Academy members must follow the Academy’s Guidelines on
Expert Witnesses (P-14.200), a copy of the Guidelines is attached to this Code of Ethics as
Appendix A and incorporated herein by reference.

Approved: Board of Directors: 12/3/05; revised: 7/29/06; 11/4/06; 5/7/11; 11/5/11
DISCLOSURE OF POTENTIAL CONFLICTS OF INTEREST

In order for the Academy to operate most effectively to further the purposes for which it is organized, it is important that Academy decisions and actions not be unduly influenced by any special interests of individual members. Therefore, it has always been and continues to be important to identify potential or actual conflicts of interest that might improperly affect Academy activities. The Academy has adopted a formal system for the disclosure and evaluation of actual and potential conflicts of interest. The principal features of that system are described below.

Conflicts of Interest Examples

1. Interests that may affect significant economic transactions to which the Academy is or may be a direct party. An example would be ownership by an Academy officer of a company from which the Academy makes major purchases of goods or services.

2. Interests that might cause a representative of the Academy to abuse an Academy position to achieve objectives that are inconsistent with the purposes of the Academy. An example of such exploitation would be a council or committee chair unfairly maligning a company that competes with a company in which the chair has a personal financial interest.

3. Interests that bear significantly on issues of importance to the Academy membership and about which different components of the Academy membership might hold widely differing views. An example would be the interests/potential biases associated with a member being employed by a government agency, medical device, or pharmaceutical company when the member is in a position to influence the development of Academy position statements, policies or clinical guidelines.

In many cases, disclosure of the potentially conflicting interest will itself suffice to protect the integrity of Academy operations. In other words, once such an interest is fully disclosed to the other participants in any related Academy activity, those other participants will generally be able to evaluate and adjust for the possible influence of the disclosed interest.

However, it is important to bear in mind that in certain situations, adequate protection of the interests of the Academy may require scrupulous avoidance of even the appearance of conflict of interest, abuse or impropriety. In those situations where mere disclosure does not appear adequate to deal with actual or potential problems, additional action may be necessary.

Disclosure Process

1. Identifying possible conflicts of interest by individuals occupying leadership positions. The individuals covered by this procedure are the officers, all other members of the Board of Directors, the editors of *Journal of American Academy of Dermatology (JAAD)* (including associate and assistant editors) and the editor of *Dermatology World*, all chairs and members of councils, committees, task forces, ad hoc task forces, work groups and senior staff. Annually, the individuals covered will be required to sign and submit a disclosure statement acknowledging a duty to serve the Academy in good faith and with undivided loyalty. These individuals must describe all personal or professional circumstances that might create a private interest in conflict with the interests of the Academy. Accompanying this policy statement as Exhibit A is a sample copy of such a disclosure statement.

In addition, “Key Leaders,” including the President, President-elect, Secretary-Treasurer, Executive Director, and JAAD Editor, will be required to divest themselves of any “direct financial relationships” with industry during their entire term, utilizing the time from the close of the election to the time they take office to complete the divestiture process. For purposes of Key Leader disclosures, the definition of direct financial relationship is a compensated relationship held by an individual that should generate an IRS Form W-2, 1099 or equivalent income report. Key Leaders may provide uncompensated service to for-profit companies and accept reasonable travel reimbursement in connection with those services. Key Leaders may accept research support as long as grant money is paid to the institution or practice where the research is conducted, not the individual. Compensation (e.g., royalties) from intellectual property rights does not need to be divested.
Members who do not disclose annually and who fail to update their disclosure within 30 days of acquiring a new relevant financial relationship will lose the right to hold office, serve in the governance structure and, except in unusual circumstances approved in advance by the Board of Directors, to participate in Academy programs.

**Review Process**

1. Officers, directors, chairs and members of councils, committees, and task forces, the editors of JAAD and senior staff will submit their disclosure statements online on the AAD Website with oversight by the Secretary-Treasurer.

2. The disclosure statements from committee and task force members will be forwarded to the appropriate chair to review. If necessary, the chair will forward those statements that appear to have conflicts that could prevent the member from serving to the Secretary-Treasurer with any relevant observations or recommendations.

3. The Secretary-Treasurer will review the disclosure statements submitted by the chairs and forward those that require further review to the Ethics Committee, while at the same time informing the Board of Directors of any conflicts that appear especially significant. If clarification is needed around Academy conflict of interest policies or guidance is needed on specific questions and cases regarding definition and resolution program areas, the Ethics Committee will utilize the Oversight Committee for guidance.

4. The Ethics Committee will review and initiate any request for further information and promptly prepare a report to the Secretary-Treasurer regarding its findings. The Secretary-Treasurer will report to the Board of Directors on any items found by the Committee to be of special significance.

All electronic disclosure statements will be retained at the Academy headquarters office. They will be available electronically for review by members of the Board of Directors and staff, and, upon request, by Academy members. They will be available to the council, committee, task force, ad hoc task force and work group members to review prior to all conference calls and meetings. Chairs of councils, committee, ad hoc task forces, task forces, and work groups are required to make a statement in the summation reports of any conflicts of interest that have been expressed by a member during a meeting or conference call.

Members are also required to verbally disclose and update their conflict of interest form for any relevant conflicts that may occur during a conference call or meeting that do not already appear on the disclosure form.

As noted above, some situations involving actual or potential conflicts of interest may call for action beyond disclosure. In some cases, there may be a need for the governing entity to further discuss a potential conflict of interest and determine whether the issue rises to the level where the member may speak to the issue but not vote or may be asked to recue him or herself from the discussion and voting. The basic authority and procedures established by corporate law and the Academy bylaws will be available to deal with any substantial conflict of interest problems. For example, the normal disciplinary standards and procedures described in Sections 7 and 8 of Article IV of the Academy bylaws can be invoked to discipline any member whose conflict of interest produces a violation of those standards. As another example, council, committee, ad hoc task force, task force and work group chairs, all of whom serve by virtue of approval by the Board of Directors, are subject to removal by the Board of Directors if a particular conflict of interest is deemed sufficiently serious or a member refuses to submit a current disclosure form. As to the officers and directors themselves, they continue to be subject to basic legal constraints arising out of the fiduciary nature of their relationships with the Academy, and in appropriate circumstances, the Board of Directors can deal with misconduct in office or seek court intervention.
2. **Standing Rule Regarding Disclosure of Interests by Participants in Debate at an Academy Membership Meeting.** Accompanying this policy statement as Exhibit A is a copy of this standing rule. As suggested by the terms of the rule, its basic purpose is to inform the audience of aspects of a speaker's personal or professional circumstances that might affect significantly the speaker's attitude or judgment regarding the particular matter under consideration. Written notice of this rule is to be included with membership meeting notices, and the rule is also to be announced at each meeting by the presiding officer.

3. **Continuing Medical Education and Maintenance of Certification Activities.** As a CME provider accredited by the Accreditation Council of Continuing Medical Education (ACCME), the Academy has established policies and procedures to identify and resolve conflicts of interest for all individuals in a position to control the content of an educational activity. This includes but is not limited to the planning committee members, session directors, speakers (“faculty”), presenters, moderators, authors, peer reviewers and staff.

4. **Standing Rule Regarding Disclosure of Interests by Speakers at Academy Scientific Sessions.** Accompanying this policy statement as Exhibit B is a copy of that rule. As in the case of the rule regarding disclosure during debate at a business meeting of the Academy membership, this rule is intended to bring possible bias to the attention of the audience so that the members of the audience can evaluate the program content accordingly. Written notice of this rule is to be sent to the directors of, and prospective speakers at, symposia and other scientific programs, and the directors are to announce the rule at each scientific session.

5. **Evidence-Based Clinical Guideline Development.** The Academy is committed to minimizing the potential for health industry influence on the development of clinical guidelines of care and creating these documents with full transparency. Guideline work group members are required to disclose all relevant conflicts prior to their work group appointments and throughout guideline development in order to identify, resolve and manage potential conflicts. Accompanying this policy statement as Exhibit D is Appendix A of the Administrative Regulations for Evidence-Based Guidelines that details the requirements for disclosure and management of all guideline contributors and approving bodies during guideline production and review.

6. **Journal of the American Academy of Dermatology (JAAD) Conflict of Interest Statement.** This disclosure of potential conflict of interest seeks to identify sources of bias that might affect the presentation of scientific analysis or opinion. It relates to disclosure of certain types of interests by the authors of manuscripts submitted for possible publication in JAAD. The primary areas of concern are:

   1. financial support from pharmaceutical and device companies or other commercial sources for research that is the subject of a JAAD manuscript and
   2. Financial interests on the part of authors in any products or services related to the subject matter of a JAAD manuscript.

   Accompanying this policy statement as Exhibit C is a sample copy of a disclosure statement to be signed by each author of a manuscript submitted to JAAD. Disclosure of any potential conflict will alert the editors to the possibility of bias in the presentation, and it might also be appropriate in certain circumstances to publish information about the disclosed interest with the article in question so that each reader will have an opportunity to evaluate and adjust for the possible bias.
Because proper disclosure by each individual author, speaker, member volunteer or Academy leader is essential if the system is to function satisfactorily, it is important for everyone involved to approach with the proper perspective the question of what types of circumstances call for disclosure. The purpose of the procedure is not to discourage all involvement by Academy members in outside activities that might produce actual or potential conflicts with interests of the Academy. Neither is the objective to intrude into aspects of an individual's professional or personal life that are, realistically, unlikely to have any significant bearing on Academy activities. Common sense should guide all decisions about what to disclose, and one reasonable test is whether a particular circumstance, interest or relationship, if made known to the full membership of the Academy or to the general public, would be likely to create the perception of impropriety, cause embarrassment for the Academy and/or the individual involved, or evoke suspicion about the motives behind any Academy action.

Approved: Board of Directors: 6/18/88; revised: 2/27/98; 3/19/99; 5/20/06; 02/3/07; 4/21/07; 6/15/10; 11/13/10
Re: Article IV, Sections 7 and 8

JUDICIAL PANEL – DISCIPLINARY PROCEDURES

A. Initiation of Complaint

1. Disciplinary action may be initiated by any member of the Academy or by the Ethics Committee. A complaint by a member may be submitted to the Executive Director of the Academy. Such charges may be made against any class of member. All charges shall be in writing and shall specify the basis for the complaint, including, where applicable, the provision of the Academy Bylaws or Ethics Code that has allegedly been violated or other conduct justifying disciplinary action.

B. Procedure for Processing Complaint

1. The Executive Director shall forward copies of the charge to the President, the Secretary-Treasurer, the Chair of the Ethics Committee, and legal counsel. If the Chair of the Ethics Committee and the Secretary-Treasurer, after consultation with the President, the Executive Director, and legal counsel, determine that a charge is not in compliance with the bylaws or guidelines, could not be the basis for disciplinary action by the Academy if proven, or involves testimony in pending litigation, the complaint will be rejected and returned to the Complainant with a statement of the reasons for such decision. With respect to any remaining portion of the complaint, the Executive Director, Secretary-Treasurer, or Chair of the Ethics Committee will contact the Complainant to determine whether there are any further documents or exhibits that he/she would like to submit in support of the complaint. A copy of the Academy Bylaws and these Procedures will be sent to the Complainant. Testimony of prospective witnesses should be summarized and submitted in written form, or transcripts of their testimony produced, if germane to the complaint. It is the Complainant’s responsibility to collect and present all evidence that he/she wishes the Academy to consider in support of the complaint. Complainant will be advised that the Academy’s disciplinary proceedings are confidential until the final disposition of the complaint is rendered, at which time the decision will be published in the manner set forth in the Academy’s Administrative Regulations on Disciplinary Action. The Complainant will also be advised that the Academy will send the complaint with all accompanying materials, including the complainant’s identity, to the subject of the complaint (“the Respondent”). In addition, the Academy will inform the complainant that he/she has the right to withdraw the complaint. If the complainant decides to withdraw the complaint, the Ethics Committee may exercise its discretion to initiate a complaint against the respondent and will keep the original complainant’s identity anonymous; provided that the Ethics Committee will not initiate a complaint if doing so without identifying the original complainant would likely violate the respondent’s due process rights.

2. The Respondent will be notified that a complaint has been lodged against him or her along with the basis for the complaint, as well as the confidential nature of the proceedings. The Respondent will be furnished with a full set of the documents and other materials submitted by the Complainant, including the complaint and any supporting evidence. The Respondent will then have thirty (30) days to prepare and submit whatever written responses, documents, and/or exhibits he/she believes are appropriate.

3. The Respondent shall be furnished with a copy of these Procedures informing the physician of his/her rights throughout this process.

4. The Executive Director will forward copies of all of the documents submitted by the Complainant and the Respondent to the President, the Secretary-Treasurer, and the Chair of the Ethics Committee.
C. Preliminary Evaluation

1. The Ethics Committee shall review the written submissions made by both sides and make a preliminary finding as to whether or not a prima facie case has been asserted—i.e., whether the allegations, if proven to be true, would constitute a violation of the Academy's Bylaws, Principles of Professional Conduct, or Code of Ethics, or other conduct justifying disciplinary action. No member of the Ethics Committee may be an economic competitor of the Respondent or otherwise have a conflict of interest.

2. If the Ethics Committee decides that a prima facie case has not been established and that further review is not justified, the case will be dismissed and the Complainant and the Respondent will be notified of the Committee's decision.

3. If the Ethics Committee decides, after reviewing the documents submitted by both sides, that a prima facie case has been established, the Committee will refer the matter to a Judicial Panel appointed by the President-Elect for further consideration.

4. The Judicial Panel, including the Chair, shall consist of five Fellows in good standing from geographically diverse regions. No member of the Board of Directors or Ethics Committee of the Academy may serve on the Judicial Panel. The members shall be appointed to serve for a term of four years and until their successors shall have been appointed and assumed office. At the initial appointment of the Judicial Panel, the terms shall be appropriately staggered to ensure that the terms of two members will expire each year. No member of the Judicial Panel may be an economic competitor of the Respondent or otherwise have a conflict of interest. In the event that one or more member(s) of Judicial Panel must recuse themselves from serving, the Chair or (if the Chair has recused him or herself) the Chair's designee shall determine if there are enough remaining members to adequately investigate the case. If the Chair determines that more members are required to adequately perform the Panel's duties, the President will appoint the number of additional members requested by the Chair (not to exceed the number of recused members). The non-recused members of the Panel along with replacement member(s) appointed by the President would then review the case.

5. The Judicial Panel shall review and evaluate the charge(s) and may request the Executive Director of the Academy to coordinate an investigation of the circumstances of the charge(s). After such preliminary consideration, the Judicial Panel may by a majority vote dismiss the charge(s), and such action shall be final. If the Judicial Panel decides that disciplinary action may be warranted, the Academy shall provide Respondent with prompt notice of the Judicial Panel's proposed decision and the reasons for that decision. The notice shall also state that the Respondent has the right to request a hearing within thirty (30) days of receipt of the notice and shall provide a summary of the Respondent's rights in the hearing in accordance with these procedures. The notice will also inform the Respondent that he or she must bear his or her own expenses of attending the hearing. Hearings before the Judicial Panel may be held during the annual meeting of the Academy or at such other time and place as the Judicial Panel may, in its discretion, determine.

6. If Respondent fails to request a hearing in a timely manner, he/she shall be deemed to have waived the right to be present, and the hearing shall proceed without the Respondent pursuant to the procedures set forth in Section D below, modified accordingly by the chair of the Judicial Panel, in consultation with legal counsel, to reflect Respondent's absence.

D. Procedures for Judicial Panel Hearing/Decision

1. At least thirty days and not more than six months prior to the formal hearing on the charge(s), the Chair of the Judicial Panel shall deliver to the Respondent by registered
or certified mail a description of the charge(s) and all relevant supporting information, notice of the time and place of the hearing, and notice that he or she may appear at the hearing in person and accompanied by counsel or such other representative(s) as he or she may deem appropriate to present such information as he or she may deem appropriate regarding the charge(s). The notice will again include a copy of these Procedures. It will also include a list of witnesses (if any) expected to testify against the Respondent.

2. Prior to the hearing, the Respondent may prepare and submit a written statement regarding any matter relating to the charge(s). Legal counsel may assist the Respondent in preparing such a written statement. The Respondent may also submit any other information on his or her own behalf for consideration by the Judicial Panel.

3. At the hearing before the Judicial Panel, the Chair of the Judicial Panel shall present the original charge(s) and all substantiating information. The Respondent and/or his counsel or other representative(s) shall have an opportunity to be heard, to rebut the information presented by the Chair, to present and examine witnesses, to introduce written evidence, to cross-examine or challenge any witness presented against him or her, and to present such information on the Respondent’s behalf as the member deems proper to refute the charge(s).

4. A record shall be kept of that part of the hearing during which information is presented and the Respondent appears. The mechanism of recordation shall be established by the Judicial Panel and may be accomplished by the use of a court reporter, electronic recording unit, detailed transcription, or by the taking of adequate minutes. The Respondent will be entitled to obtain a copy of the record of the hearing at his or her own expense.

5. The hearing need not be conducted according to the rules of law relating to the examination of witnesses or the presentation of evidence. All information determined by the Chair to be related to the charge(s) shall be admissible at the hearing, whether or not such information would be admissible in a court of law. The Chair shall have the authority to impose reasonable limitations on the time available for both direct testimony and cross examination. The hearing shall be closed to all except members of the Judicial Panel, Respondent, witnesses, legal counsel, and the court reporter (if any). The purpose of the hearing shall be to assemble as much information as practicable regarding all material aspects of the charge(s), and the Judicial Panel shall be entitled to take into account any such information.

6. If Respondent fails without good cause to appear and proceed at a hearing before the Judicial Panel he/she shall be deemed to have waived his right to such hearing and to have accepted the decision of the Panel. The Judicial Panel may, for good cause, postpone a previously scheduled hearing. The Judicial Panel may, without special notice, recess the hearing and reconvene for the convenience of the participants, for the purpose of obtaining new or additional information, or for consultation.

7. Upon conclusion of the presentation of oral and written information, the hearing before the Judicial Panel shall be closed. The Respondent may submit a written statement at the close of the hearing. The Panel (with the presence of Academy legal counsel), in closed session, either immediately following the hearing, or at a time convenient to its members, shall conduct its deliberations and determine whether to recommend disciplinary action to the Board of Directors of the Academy.
E. Board Review/Decision

1. Within thirty days after the hearing of the Judicial Panel, the Judicial Panel shall deliver its proposed written decision regarding the disposition of the charge(s) to the Executive Director or Secretary-Treasurer, who shall forward the written decision to the Board of Directors and, by registered or certified mail, to the Respondent and the Complainant. If the decision of the Judicial Panel is to exonerate the Respondent, the action of the Judicial Panel shall be final. If the Judicial Panel decides that disciplinary action is warranted, the Judicial Panel shall recommend to the Board of Directors the form of disciplinary action from the options set forth in the Academy's Administrative Regulations on Disciplinary Action, and final action on the charge(s) shall be taken by the Board of Directors at a regularly- or specially-scheduled meeting.

2. At least thirty days prior to the meeting of the Board of Directors at which the charge(s) and recommendations of the Judicial Panel will be considered, the Secretary-Treasurer shall notify the Respondent by registered or certified mail of the time and place of the meeting and shall inform the Respondent that he or she may appear at the meeting in person, accompanied by counsel or other representative(s), to present objections to the recommendations of the Judicial Panel and/or to present additional information relating to the charge(s).

3. At the Board meeting, the Chair of the Judicial Panel shall present to the Board of Directors the recommendation of the Judicial Panel and all information relied upon by the Judicial Panel in formulating its recommendation. The Respondent and/or his or her counsel or other representative shall have the opportunity to be heard, to rebut the information presented by the Chair of the Judicial Panel; provided, however, that no new evidence or witnesses may be presented to or considered by the Board. The Board may set reasonable limitations on the length of the oral presentations.

4. A record shall be kept of that part of the hearing during which information is presented and the Respondent appears. The mechanism of recordation shall be established by the Board of Directors, and may be accomplished by the use of a court reporter, electronic recording unit, detailed transcription, or by the taking of adequate minutes.

5. Upon conclusion of the presentation of oral and written information, the hearing before the Board of Directors shall be closed. The Board, in executive session, either immediately following the hearing, or at a time as soon as possible thereafter shall conduct its deliberations and determine whether to discipline the Respondent. The Board of Directors may accept, reject or modify the recommendation of the Judicial Panel, and an affirmative vote of at least two-thirds of the members of the Board of Directors present at the hearing shall be required to approve any disciplinary action. The Board's decision must be based on a reasonable belief that the action is warranted by the facts presented in the documents and the Judicial Panel hearing. The action of the Board of Directors shall be final, and written notice of the action of the Board shall be delivered by registered or certified mail to the Respondent and the Complainant within thirty days after the hearing before the Board, including a statement of the reasons for such decision.

The Board of Directors of the American Academy of Dermatology may, upon its determination that disciplinary action against a member is warranted, impose disciplinary action in one of the following forms:

1. Admonition or censure, a firm reprimand in the form of a written notification, warning or serious rebuke, indicating the Academy's condemnation of the member's action as wrong.
2. Probation, a punitive action for a stated period of time, during which the member:
   a. Loses the right to hold office and, except in unusual circumstances approved in advance by the Board of Directors, to participate in Academy programs as a faculty member, presenter, or scientific exhibit contributor,
   b. Retains other privileges and obligations of membership,
   c. Is observed by the Academy for continuing eligibility for membership, and
   d. May be reconsidered by the Board of Directors periodically and at the end of the probationary period.

3. Suspension, a severe punitive action for a stated or indefinite period of time, during which:
   a. The member's name is removed from the roster and mailing list of the Academy.
   b. The member's eligibility for Academy insurance programs is canceled.
   c. The member's membership certificate shall be returned to the Academy.
   d. The member must pay visitor's registration fees when attending Academy meetings.
   e. The member loses the right to hold office and, except in unusual circumstances approved in advance by the Board of Directors, to participate in Academy programs as a faculty member, presenter, or scientific exhibit contributor.
   f. The member is excused from paying annual dues.

At the end of a stated period of suspension or at such other time as the Board of Directors may determine, and upon payment by the member of dues deferred and accrued during the period of suspension, the member shall again assume full privileges and obligations of members.

4. Termination. Certificate of membership and all other indicia of membership previously issued to the member by the American Academy of Dermatology shall be forthwith returned to the American Academy of Dermatology. The physician shall not hold himself out to be, or represent in any way that he is, a member of the American Academy of Dermatology.

5. Immediate Action. Each Academy member has an affirmative obligation to promptly inform the Academy's Executive Director or Secretary-Treasurer if any medical licensing authority revokes, suspends, or otherwise restricts the medical practice license of such member or takes any other disciplinary action against the member, the member voluntarily surrenders his or her medical license while a proposed disciplinary action by any medical licensing authority is pending against such member, or the member is indicted or convicted of a felony. If any such action is taken, the Academy membership of the individual in question shall be automatically terminated or suspended, or otherwise restricted, or the Academy may take other disciplinary action against the member, in accordance with the provisions set forth below. Failure to promptly report an adverse action against one's medical license or a felony conviction against the member will constitute separate grounds for disciplinary action.

   a. The Executive Director shall obtain from the appropriate governmental authorities a reasonable form of verification of the disciplinary action taken by a medical licensing authority, or surrender of license, or felony indictment/conviction18.

   b. After obtaining the verification referred to in subparagraph (a) above, the Secretary-Treasurer shall give the member written notice setting forth the relevant facts and informing the member that his or her Academy membership will be automatically terminated or suspended, or the member will be subject to other disciplinary action.

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18 On 3/6/10 the Board approved, the term “felony indictment”, in Section 5 of the Academy's disciplinary regulations, which permits the Academy to take disciplinary action based on a felony indictment against a member, to means any type of felony charge (i.e., either by criminal complaint or grand jury indictment.)
disciplinary action, as the case may be, thirty (30) days after said notice unless
the member provides, within that thirty (30)-day period, information indicating,
to the satisfaction of the Secretary-Treasurer, that the information on which the
membership termination or suspension, or other disciplinary action, is to be based
is erroneous or that there is some other compelling reason to defer or modify
the Academy’s decision. In such event, the Secretary-Treasurer shall conduct such
additional investigation as the Secretary-Treasurer shall deem appropriate, and fol-
lowing such investigation the Secretary-Treasurer may, if all information obtained
so warrants, (i) issue another notice of membership termination, suspension, or
other disciplinary action pursuant to this subparagraph (b), or (ii) the Secretary-
Treasurer may, in his or her discretion, defer or modify the Academy’s decision
based on a finding that the initial information obtained by the Academy was erro-
neous or if compelling circumstances so warrant.

The Secretary-Treasurer’s final action in such cases shall be subject to approval by
the Board of Directors.

c. If the factual basis for membership termination, suspension, or other disciplinary
action, set forth in a notice pursuant to subparagraph (b), above, is not challenged
(on grounds satisfactory to the Secretary-Treasurer) by the member in question
within thirty (30) days after the giving of such notice, the membership in question
shall be automatically terminated or suspended, or other disciplinary action will
automatically take effect in accordance with subparagraph (d), subparagraph (e),
or subparagraph (f), below, upon the expiration of said thirty (30)-day period.

d. If the action taken pursuant to this paragraph (5) is based upon revocation of a medi-
cal practice license, then the action taken shall be termination of Academy member-
ship. An individual whose membership is so terminated may not apply for readmission
to the Academy less than two (2) years after the date of such termination.

e. If action pursuant to this paragraph (5) is based upon suspension of a medical
practice license, then the action taken shall be suspension of Academy membership,
and that suspension of Academy membership shall extend until the end of the
period for which the medical practice license is suspended. Upon the conclusion of
that suspension period, the member in question shall automatically return to the
membership status which he or she held prior to the suspension; provided, how-
ever, that automatic suspension of Academy membership pursuant to this subpara-
graph shall not preclude the Academy from taking additional disciplinary action,
pursuant to other provisions of this Section, on the basis of the same actions or
events giving rise to such automatic suspension.

f. If the action taken pursuant to this paragraph (5) is based upon another type of
license restriction or disciplinary action, a voluntary surrender of medical license,
or an indictment or conviction of a felony, then the action taken pursuant to this
shall be any of the available disciplinary actions set forth in this Section, includ-
ing but not limited to termination or automatic suspension. An individual whose
membership is terminated under this subparagraph may not apply for readmission
to the Academy less than two (2) years after the date of such termination. If the
action taken pursuant to this subparagraph is suspension of Academy membership,
the suspension shall extend for such period as the Secretary-Treasurer recommends
and Board of Directors determines to be warranted by the facts and circum-
stances. Upon conclusion of that suspension period, the member in question shall
automatically return to the membership status which he or she held prior to the
suspension; provided, however, that automatic suspension of Academy membership pursuant to this subparagraph shall not preclude the Academy from taking additional disciplinary action, pursuant to other provisions of this Section, on the basis of the same actions or events giving rise to such automatic suspension.

Information concerning any of these actions may be reported to the National Practitioners Data Bank and appropriate State Boards of Medical Examiners. This information may also be reported to the American Board of Dermatology and/or local dermatologic societies if the circumstances so warrant.

Approved: Board of Directors: 9/10/82; revised: 10/31/87; 12/3/05; 3/4/06; 8/5/07; 3/6/10; 11/5/11

II. AMA ETHICS STATEMENTS

Principles of Medical Ethics

Preamble

The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsibility to patients first and foremost, as well as to society, to other health professionals, and to self. The following Principles adopted by the American Medical Association are not laws, but standards of conduct which define the essentials of honorable behavior for the physician.

Principles of medical ethics

I. A physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights.

II. A physician shall uphold the standards of professionalism, be honest in all professional interactions, and strive to report physicians deficient in character or competence, or engaging in fraud or deception, to appropriate entities.

III. A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient.

IV. A physician shall respect the rights of patients, colleagues, and other health professionals, and shall safeguard patient confidences and privacy within the constraints of the law.

V. A physician shall continue to study, apply, and advance scientific knowledge, maintain a commitment to medical education, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.

VI. A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical care.

VII. A physician shall recognize a responsibility to participate in activities contributing to the improvement of the community and the betterment of public health.

VIII. A physician shall, while caring for a patient, regard responsibility to the patient as paramount.

IX. A physician shall support access to medical care for all people.

Adopted June 1957; revised June 1980; revised June 2001.
Advertising and Publicity

There are no restrictions on advertising by physicians except those that can be specifically justified to protect the public from deceptive practices. A physician may publicize him or herself as a physician through any commercial publicity or other form of public communication (including any newspaper, magazine, telephone directory, radio, television, direct mail, or other advertising) provided that the communication shall not be misleading because of the omission of necessary material information, shall not contain any false or misleading statement, or shall not otherwise operate to deceive.

Because the public can sometimes be deceived by the use of medical terms or illustrations that are difficult to understand, physicians should design the form of communication to communicate the information contained therein to the public in a readily comprehensible manner. Aggressive, high-pressure advertising and publicity should be avoided if they create unjustified medical expectations or are accompanied by deceptive claims. The key issue, however, is whether advertising or publicity, regardless of format or content, is true and not materially misleading. The communication may include (1) the educational background of the physician, (2) the basis on which fees are determined (including charges for specific services), (3) available credit or other methods of payment, and (4) any other non-deceptive information.

Nothing in this opinion is intended to discourage or to limit advertising and representations which are not false or deceptive within the meaning of Section 5 of the Federal Trade Commission Act. At the same time, however, physicians are advised that certain types of communications have a significant potential for deception and should therefore receive special attention. For example, testimonials of patients as to the physician's skill or the quality of the physician's professional services tend to be deceptive when they do not reflect the results that patients with conditions comparable to the testimoniant's condition generally receive.

Objective claims regarding experience, competence, and the quality of physicians and the services they provide may be made only if they are factually supportable. Similarly, generalized statements of satisfaction with a physician's services may be made if they are representative of the experiences of that physician's patients.

Because physicians have an ethical obligation to share medical advances, it is unlikely that a physician will have a truly exclusive or unique skill or remedy. Claims that imply such a skill or remedy therefore can be deceptive. Statements that a physician has an exclusive or unique skill or remedy in a particular geographic area, if true, however, are permissible. Similarly, a statement that a physician has cured or successfully treated a large number of cases involving a particular serious ailment is deceptive if it implies a certainty of result and creates unjustified and misleading expectations in prospective patients.

Consistent with federal regulatory standards which apply to commercial advertising, a physician who is considering the placement of an advertisement or publicity release, whether in print, radio, or television, should determine in advance that the communication or message is explicitly and implicitly truthful and not misleading. These standards require the advertiser to have a reasonable basis for claims before they are used in advertising. The reasonable basis must be established by those facts known to the advertiser, and those which a reasonable, prudent advertiser should have discovered. Inclusion of the physician's name in advertising may help to assure that these guidelines are being met. (II)

Opinion 5.02 Report: Issued prior to April 1977; Updated June 1996
Use of Chaperones During Physical Exams

From the standpoint of ethics and prudence, the protocol of having chaperones available on a consistent basis for patient examinations is recommended. Physicians aim to respect the patient’s dignity and to make a positive effort to secure a comfortable and considerate atmosphere for the patient; such actions include the provision of appropriate gowns, private facilities for undressing, sensitive use of draping, and clear explanations on various components of the physical examination. A policy that patients are free to make a request for a chaperone should be established in each health care setting. This policy should be communicated to patients, either by means of a well-displayed notice or preferably through a conversation initiated by the intake nurse or the physician. The request by a patient to have a chaperone should be honored.

An authorized health professional should serve as a chaperone whenever possible. In their practices, physicians should establish clear expectations about respecting patient privacy and confidentiality to which chaperones must adhere. If a chaperone is to be provided, a separate opportunity for private conversation between the patient and the physician should be allowed. The physician should keep inquiries and history-taking, especially those of a sensitive nature, to a minimum during the course of the chaperoned examination. (I, IV)

Gifts to Physicians from Industry

Many gifts given to physicians by companies in the pharmaceutical, device, and medical equipment industries serve an important and socially beneficial function. For example, companies have long provided funds for educational seminars and conferences. However, there has been growing concern about certain gifts from industry to physicians. Some gifts that reflect customary practices of industry may not be consistent with the Principles of Medical Ethics. To avoid the acceptance of inappropriate gifts, physicians should observe the following guidelines:

1. Any gifts accepted by physicians individually should primarily entail a benefit to patients and should not be of substantial value. Accordingly, textbooks, modest meals, and other gifts are appropriate if they serve a genuine educational function. Cash payments should not be accepted. The use of drug samples for personal or family use is permissible as long as these practices do not interfere with patient access to drug samples. It would not be acceptable for non-retired physicians to request free pharmaceuticals for personal use or use by family members.

2. Individual gifts of minimal value are permissible as long as the gifts are related to the physician’s work (e.g., pens and notepads).

3. The Council on Ethical and Judicial Affairs defines a legitimate “conference” or “meeting” as any activity, held at an appropriate location, where (a) the gathering is primarily dedicated, in both time and effort, to promoting objective scientific and educational activities and discourse (one or more educational presentation(s) should be the highlight of the gathering), and (b) the main incentive for bringing attendees together is to further their knowledge on the topic(s) being presented. An appropriate disclosure of financial support or conflict of interest should be made.

4. Subsidies to underwrite the costs of continuing medical education conferences or professional meetings can contribute to the improvement of patient care and therefore are permissible. Since the giving of a subsidy directly to a physician by a company’s
representative may create a relationship that could influence the use of the company's products, any subsidy should be accepted by the conference's sponsor who in turn can use the money to reduce the conference's registration fee. Payments to defray the costs of a conference should not be accepted directly from the company by the physicians attending the conference.

(5) Subsidies from industry should not be accepted directly or indirectly to pay for the costs of travel, lodging, or other personal expenses of physicians attending conferences or meetings, nor should subsidies be accepted to compensate for the physicians' time. Subsidies for hospitality should not be accepted outside of modest meals or social events held as a part of a conference or meeting. It is appropriate for faculty at conferences or meetings to accept reasonable honoraria and to accept reimbursement for reasonable travel, lodging, and meal expenses. It is also appropriate for consultants who provide genuine services to receive reasonable compensation and to accept reimbursement for reasonable travel, lodging, and meal expenses. Token consulting or advisory arrangements cannot be used to justify the compensation of physicians for their time or their travel, lodging, and other out-of-pocket expenses.

(6) Scholarship or other special funds to permit medical students, residents, and fellows to attend carefully selected educational conferences may be permissible as long as the selection of students, residents, or fellows who will receive the funds is made by the academic or training institution. Carefully selected educational conferences are generally defined as the major educational, scientific or policy-making meetings of national, regional, or specialty medical associations.

(7) No gifts should be accepted if there are strings attached. For example, physicians should not accept gifts if they are given in relation to the physician's prescribing practices. In addition, when companies underwrite medical conferences or lectures other than their own, responsibility for and control over the selection of content, faculty, educational methods, and materials should belong to the organizers of the conferences or lectures.

Clarification of Opinion 8.061

“Gifts to Physicians from Industry,” is intended to provide ethical guidance to physicians. Other parties involved in the health care sector, including the pharmaceutical, devices, and medical equipment industries and related entities or business partners, should view the guidelines as indicative of standards of conduct for the medical profession. Ultimately, it is the responsibility of individual physicians to minimize conflicts of interest that may be at odds with the best interest of patients and to access the necessary information to inform medical recommendations.

The guidelines apply to all forms of gifts, whether they are offered in person, through intermediaries, or through the Internet. Similarly, limitations on subsidies for educational activities should apply regardless of the setting in which, or the medium through which, the educational activity is offered.

General Questions

(a) Do the guidelines apply only to pharmaceutical, device, and equipment manufacturers?

“Industry” includes all “proprietary health-related entities that might create a conflict of interest.”

Guideline 1

Any gifts accepted by physicians individually should primarily entail a benefit to patients and should not be of substantial value. Accordingly, textbooks, modest meals, and other gifts are appropriate if they serve a genuine educational function. Cash payments should not be accepted. The use of drug samples for personal or family use is permissible as long as these practices do not interfere with patient access to drug samples. It would not be acceptable for non-retired physicians to request free pharmaceuticals for personal use or for use by family members.

(a) May physicians accept gram stain test kits, stethoscopes, or other diagnostic equipment?

Diagnostic equipment primarily benefits the patient. Hence, such gifts are permissible as long as they are not of substantial value. In considering the value of the gift, the relevant measure is not the cost to the company of providing the gift. Rather, the relevant measure is the cost to the physician if the physician purchased the gift on the open market.

(b) May companies invite physicians to a dinner with a speaker and donate $100 to a charity or medical school on behalf of the physician?

There are positive aspects to the proposal. The donations would be used for a worthy cause, and the physicians would receive important information about patient care. There is a direct personal benefit to the physician as well, however. An organization that is important to the physician-and one that the physician might have ordinarily felt obligated to make a contribution to-receives financial support as a result of the physician’s decision to attend the meeting. On balance, physicians should make their own judgment about these inducements. If the charity is predetermined without the physician’s input, there would seem to be little problem with the arrangement.

(c) May contributions to a professional society’s general fund be accepted from industry?

The guidelines are designed to deal with gifts from industry which affect, or could appear to affect, the judgment of individual practicing physicians. In general, a professional society should make its own judgment about gifts from industry to the society itself.
(d) When companies invite physicians to a dinner with a speaker, what are the relevant guidelines?

First, the dinner must be a modest meal. Second, the guideline does allow gifts that primarily benefit patients and that are not of substantial value. Accordingly, textbooks and other gifts that primarily benefit patient care and that have a value to the physician in the general range of $100 are permissible. When educational meetings occur in conjunction with a social event such as a meal, the educational component must have independent value, such as a presentation by an authoritative speaker other than a sales representative of the company. Also, the meal should be a modest one similar to what a physician routinely might have when dining at his or her own expense. In an office or hospital encounter with a company representative, it is permissible to accept a meal of nominal value, such as a sandwich or snack.

(e) May physicians accept vouchers that reimburse them for uncompensated care they have provided?

No. Such a voucher would result directly in increased income for the physician.

(f) May physicians accumulate “points” by attending several educational or promotional meetings and then choose a gift from a catalogue of education options?

This guideline permits gifts only if they are not of substantial value. If accumulation of points would result in physicians receiving a substantial gift by combining insubstantial gifts over a relatively short period of time, it would be inappropriate.

(g) May physicians accept gift certificates for educational materials when attending promotional or educational events?

The Council views gift certificates as a grey area which is not per se prohibited by the guidelines. Medical textbooks are explicitly approved as gifts under the guidelines. A gift certificate for educational materials, i.e., for the selection by the physician from an exclusively medical textbook catalogue, would not seem to be materially different. The issue is whether the gift certificate gives the recipient such control as to make the certificate similar to cash. As with charitable donations, pre-selection by the sponsor removes any question. It is up to the individual physician to make the final judgment.

(h) May physicians accept drug samples or other free pharmaceuticals for personal use or use by family members?

The Council's guidelines permit personal or family use of free pharmaceuticals (i) in emergencies and other cases where the immediate use of a drug is indicated, (ii) on a trial basis to assess tolerance, and (iii) for the treatment of acute conditions requiring short courses of inexpensive therapy, as permitted by Opinion 8.19, “Self-Treatment or Treatment of Immediate Family Members.” It would not be acceptable for physicians to accept free pharmaceuticals for the long-term treatment of chronic conditions.

(i) May companies invite physicians to a dinner with a speaker and offer them a large number of gifts from which to choose one?

In general, the greater the freedom of choice given to the physician, the more the offer seems like cash. A large number of gifts presented to physicians who attend a dinner would therefore be inappropriate.

There is no precise way of deciding an appropriate upper limit on the amount of choice
that is acceptable. However, it is important that a specific limit be chosen to ensure clarity in the guidelines. A limit of eight has been chosen because it permits flexibility but prevents undue freedom of choice. Each of the choices must have a value to the physicians of no more than $100.

(j) May physicians charge for their time with industry representatives or otherwise receive material compensation for participation in a detail visit?

Guideline 1 states that gifts in the form of cash payments should not be accepted. Also, Guideline 6 makes clear that, in the context of the industry-physician relationship, only physicians who provide genuine services may receive reasonable compensation. When considering the time a physician spends with an industry representative, it is the representative who offers a service, namely the presentation of information. The physician is a beneficiary of the service. Overall, these guidelines do not view that physicians should be compensated for the time spent participating in educational activities, nor for time spent receiving detail information from an industry representative.

Guideline 2

Individual gifts of minimal value are permissible as long as the gifts are related to the physician's work (eg, pens and notepads).

(a) May physicians, individually or through their practice group, accept electronic equipment, such as hand held devices or computers, intended to facilitate their ability to receive detail information electronically?

Although Guideline 2 recognizes that gifts related to a physician’s practice may be appropriate, it also makes clear that these gifts must remain of minimal value. It is not appropriate for physicians to accept expensive hardware or software equipment even though one purpose only may pertain to industry-related activities of a modest value.

Guideline 3

The Council on Ethical and Judicial Affairs defines a legitimate “conference” or “meeting” as any activity, held at an appropriate location, where (a) the gathering is primarily dedicated, in both time and effort, to promoting objective scientific and educational activities and discourse (one or more educational presentation(s) should be the highlight of the gathering), and (b) the main incentive for bringing attendees together is to further their knowledge on the topic(s) being presented. An appropriate disclosure of financial support or conflict of interest should be made.

Guideline 4

Subsidies to underwrite the costs of continuing medical education conferences or professional meetings can contribute to the improvement of patient care and therefore are permissible. Since the giving of a subsidy directly to a physician by a company's sales representative may create a relationship which could influence the use of the company's products, any subsidy should be accepted by the conference's sponsor who in turn can use the money to reduce the conference's registration fee. Payments to defray the costs of a conference should not be accepted directly from the company by the physicians attending the conference.

(a) Are conference subsidies from the educational division of a company covered by the guidelines?

Yes. When the Council says “any subsidy,” it would not matter whether the subsidy comes from the sales division, the educational division, or some other section of the company.
(b) May a company or its intermediary send physicians a check or voucher to offset the registration fee at a specific conference or a conference of the physician's choice?

Physicians should not directly accept checks or certificates which would be used to offset registration fees. The gift of a reduced registration should be made across the board and through the accredited sponsor.

Guideline 5

Subsidies from industry should not be accepted directly or indirectly to pay for the costs of travel, lodging, or other personal expenses of physicians attending conferences or meetings, nor should subsidies be accepted to compensate for the physicians' time. Subsidies for hospitality should not be accepted outside of modest meals or social events held as a part of a conference or meeting. It is appropriate for faculty at conferences or meetings to accept reasonable honoraria and to accept reimbursement for reasonable travel, lodging, and meal expenses. It is also appropriate for consultants who provide genuine services to receive reasonable compensation and to accept reimbursement for reasonable travel, lodging, and meal expenses. Token consulting or advisory arrangements cannot be used to justify the compensation of physicians for their time or their travel, lodging, and other out-of-pocket expenses.

(a) If a company invites physicians to visit its facilities for a tour or to become educated about one of its products, may the company pay travel expenses and honoraria?

This question has come up in the context of a rehabilitation facility that wants physicians to know of its existence so that they may refer their patients to the facility. It has also come up in the context of surgical device or equipment manufacturers who want physicians to become familiar with their products.

In general, travel expenses should not be reimbursed, nor should honoraria be paid for the visiting physician's time since the presentations are analogous to a pharmaceutical company's educational or promotional meetings. The Council recognizes that medical devices, equipment, and other technologies may require, in some circumstances, special evaluation or training in proper usage which cannot practicably be provided except on site. Medical specialties are in a better position to advise physicians regarding the appropriateness of reimbursement with regard to these trips. In cases where the company insists on such visits as a means of protection from liability for improper usage, physicians and their specialties should make the judgment. In no case would honoraria be appropriate and any travel expenses should be only those strictly necessary.

(b) If the company invites physicians to visit its facilities for review and comment on a product, to discuss their independent research projects, or to explore the potential for collaborative research, may the company pay travel expenses and an honorarium?

If the physician is providing genuine services, reasonable compensation for time and travel expenses can be given. However, token advisory or consulting arrangements cannot be used to justify compensation.

(c) May a company hold a sweepstakes for physicians in which five entrants receive a trip to the Virgin Islands or airfare to the medical meeting of their choice?

No. The use of a sweepstakes or raffle to deliver a gift does not affect the permissibility of the gift. Since the sweepstakes is not open to the public, the guidelines apply in full force.
(d) If a company convenes a group of physicians to recruit clinical investigators or convenes a group of clinical investigators for a meeting to discuss their results, may the company pay for their travel expenses?

Expenses may be paid if the meetings serve a genuine research purpose. One guide to their propriety would be whether the National Institute of Health (NIH) conducts similar meetings when it sponsors multi-center clinical trials. When travel subsidies are acceptable, the guidelines emphasize that they be used to pay only for “reasonable” expenses. The reasonableness of expenses would depend on a number of considerations. For example, meetings are likely to be problematic if overseas locations are used for exclusively domestic investigators. It would be inappropriate to pay for recreation or entertainment beyond the kind of modest hospitality described in this guideline.

(e) How can a physician tell whether there is a “genuine research purpose?”

A number of factors can be considered. Signs that a genuine research purpose exists include the facts that there are (1) a valid study protocol, (2) recruitment of physicians with appropriate qualifications or expertise, and (3) recruitment of an appropriate number of physicians in light of the number of study participants needed for statistical evaluation.

(f) May a company compensate physicians for their time and travel expenses when they participate in focus groups?

Yes. As long as the focus groups serve a genuine and exclusive research purpose and are not used for promotional purposes, physicians may be compensated for time and travel expenses. The number of physicians used in a particular focus group or in multiple focus groups should be an appropriate size to accomplish the research purpose, but no larger.

(g) Do the restrictions on travel, lodging, and meals apply to educational programs run by medical schools, professional societies, or other accredited organizations which are funded by industry, or do they apply only to programs developed and run by industry?

The restrictions apply to all conferences or meetings which are funded by industry. The Council drew no distinction on the basis of the organizer of the conference or meeting. The Council felt that the gift of travel expenses is too substantial even when the conference is run by a non-industry sponsor. (Industry includes all “proprietary health-related entities that might create a conflict of interest.”)

(h) May company funds be used for travel expenses and honoraria for bona fide faculty at educational meetings?

This guideline draws a distinction between attendees and faculty. As was stated, “[i]t is appropriate for faculty at conferences or meetings to accept reasonable honoraria and to accept reimbursement for reasonable travel, lodging, and meal expenses.”

Companies need to be mindful of the guidelines of the Accreditation Council on Continuing Medical Education. According to those guidelines, “[f]unds from a commercial source should be in the form of an educational grant made payable to the CME sponsor for the support of programming.”

(i) May travel expenses be reimbursed for physicians presenting a poster or a “free paper” at a scientific conference?
Reimbursement may be accepted only by bona fide faculty. The presentation of a poster or a free paper does not by itself qualify a person as a member of the conference faculty for purposes of these guidelines.

(j) When a professional association schedules a long-range planning meeting, is it appropriate for industry to subsidize the travel expenses of the meeting participants?

The guidelines are designed to deal with gifts from industry which affect, or could appear to affect, the judgment of individual practicing physicians. In general, a professional society should make its own judgment about gifts from industry to the society itself.

(k) May continuing medical education conferences be held in the Bahamas, Europe, or South America?

There are no restrictions on the location of conferences as long as the attendees are paying their own travel expenses.

(l) May travel expenses be accepted by physicians who are being trained as speakers or faculty for educational conferences and meetings?

In general, no. If a physician is presenting as an independent expert at a CME event, both the training and its reimbursement raise questions about independence. In addition, the training is a gift because the physician's role is generally more analogous to that of an attendee than a participant. Speaker training sessions can be distinguished from meetings (See 5d) with leading researchers, sponsored by a company, designed primarily for an exchange of information about important developments or treatments, including the sponsor's own research, for which reimbursement for travel may be appropriate.

(m) What kinds of social events during conferences and meetings may be subsidized by industry?

Social events should satisfy three criteria. First, the value of the event to the physician should be modest. Second, the event should facilitate discussion among attendees and/or discussion between attendees and faculty. Third, the educational part of the conference should account for a substantial majority of the total time accounted for by the educational activities and social events together. Events that would be viewed (as in the succeeding question) as lavish or expensive should be avoided. But modest social activities that are not elaborate or unusual are permissible, e.g., inexpensive boat rides, barbecues, entertainment that draws on the local performers. In general, any such events which are a part of the conference program should be open to all registrants.

(n) May a company rent an expensive entertainment complex for a evening during a medical conference and invite the physicians attending the conference?

No. The guidelines permit only modest hospitality.

(o) If physicians attending a conference engage in interactive exchange, may their travel expenses be paid by industry?

No. Mere interactive exchange would not constitute genuine consulting services.

(p) If a company schedules a conference and provides meals for the attendees that fall within the guidelines, may the company also pay for the costs of the meals for spouses?

If a meal falls within the guidelines, then the physician’s spouse may be included.

(q) May companies donate funds to sponsor a professional society’s charity golf tournament?

Yes. But it is sensible if physicians who play in the tournament make some contribution themselves to the event.
If a company invites a group of consultants to a meeting and a consultant brings a spouse, may the company pay the costs of lodging or meals of the spouse? Does it matter if the meal is part of the program for the consultants?

Since the costs of having a spouse share a hotel room or join a modest meal are nominal, it is permissible for the company to subsidize those costs. However, if the total subsidies become substantial, then they become unacceptable.

**Guideline 6**

Scholarship or other special funds to permit medical students, residents, and fellows to attend carefully selected educational conferences may be permissible as long as the selection of students, residents, or fellows who will receive the funds is made by the academic or training institution. Carefully selected educational conferences are generally defined as the major educational, scientific, or policy-making meetings of national, regional, or specialty medical associations.

(a) When a company subsidizes the travel expenses of residents to an appropriately selected conference, may the residents receive the subsidy directly from the company?

Funds for scholarships or other special funds should be given to the academic departments or the accredited sponsor of the conference. The disbursement of funds can then be made by the departments or the conference sponsor.

(b) What is meant by “carefully selected educational conferences?”

The intent of Guideline 6 is to ensure that financial hardship does not prevent students, residents, and fellows from attending major educational conferences. For example, we did not want to deny cardiology fellows the opportunity to attend the annual scientific meeting of the American College of Cardiology or orthopedic surgery residents the opportunity to attend the annual scientific meeting of the American Academy of Orthopedic Surgeons. However, it was not the intent of the guideline to permit reimbursement of travel expenses in other circumstances, such as when conferences or symposia are designed specifically for students, residents, or fellows. Funds are limited to travel and lodging expenses for attendance at major educational, scientific, or policy-making meetings of national, regional, or specialty medical associations.

**Guideline 7**

No gifts should be accepted if there are strings attached. For example, physicians should not accept gifts if they are given in relation to the physician’s prescribing practices. In addition, when companies underwrite medical conferences or lectures other than their own, responsibility for and control over the selection of content, faculty, educational methods, and materials should belong to the organizers of the conferences or lectures.

(a) May companies send their top prescribers, purchasers, or referrers on cruises?

No. There can be no link between prescribing or referring patterns and gifts. In addition, travel expenses, including cruises, are not permissible.

(b) May the funding company itself develop the complete educational program that is sponsored by an accredited continuing medical education sponsor?

No. The funding company may finance the development of the program through its grant to the sponsor, but the accredited sponsor must have responsibility and control over the content and faculty of conferences, meetings, or lectures. Neither the funding company
nor an independent consulting firm should develop the complete educational program for approval by the accredited sponsor.

(c) How much input may a funding company have in the development of a conference, meeting, or lectures?

The guidelines of the Accreditation Council on Continuing Medical Education on commercial support of continuing medical education address this question.

III. POSITION STATEMENTS

Position Statement on Access to Specialty Care and Direct Access to Dermatologic Care

The American Academy of Dermatology believes that all Americans should have the freedom to choose their own physicians and the health insurance coverage that best meets their needs. It is this freedom of choice, coupled with the availability of specialty medicine that has distinguished the American health care system. Specialized training and care have produced numerous medical advances that have resulted in life-saving and life-enhancing treatments.

For most Americans, the health care system provides prompt and direct access to medical and surgical specialists. However, managed care now covers a major portion of the health insurance market, and the vast majority of those plans restrict access to specialty care and patient choice.

The Academy believes that health insurance plans should not set barriers or impediments to appropriate specialized medical services. Direct access to specialty care is essential for patients in emergency and non-emergency situations and for patients with chronic and temporary conditions. Health insurance plans must provide a full range of specialists for their enrollees. Specialty care must be available for the full duration of the illness and not be limited by time or the number of physician visits. Every health insurance plan should cover a patient's care by the physician of his or her choice whether in-network or out-of-network. Likewise, the Academy supports all patients having direct access to dermatologic care delivered by dermatologists. Patients in managed care settings should be able to visit a dermatologist without first receiving a referral from a gatekeeper or primary care physician because patients are able to visually determine a problem with regard to the skin. Any patient with a chronic skin condition should be able to elect a dermatologist as their primary physician within a plan.

Direct access to dermatologists is the easiest and most cost-effective method of providing quality dermatologic services in managed care settings. Studies have indicated that dermatologists are more cost-effective and provide higher quality of care to patients with skin diseases. Improper diagnosis of skin diseases results in: additional costs from unnecessary diagnostic tests, office visits or treatments; possible complications from unnecessary treatments; and prolonged patient suffering. Patients experience loss of income and productivity from missed work due to misdiagnosis. There may even be increased morbidity and potential mortality from delayed diagnosis and treatment. It is critical; therefore, that every patient in a managed care setting have direct access to dermatologic services delivered by a dermatologist.

Approved by the Board of Directors 3/21/97
Position Statement on Capitation’s Impact on Medical Ethics

The basic tenets of the ethical practice of medicine are based on the following principles:

1) non-maleficence,
2) beneficence,
3) autonomy, and
4) distributive justice.

“Non-maleficence” is the standard term for “do no harm.” “Beneficence” simply means that every encounter with a patient should yield a positive benefit. “Autonomy” refers, in this case, to the simple concept that no physician can serve two masters; the physician’s obligation is to do what is best for the patient, regardless of what another third party is dictating to the contrary. “Distributive justice” means that the physician has the ethical responsibility to try to distribute medical resources to the community in a manner that tries to help the poor as well as the affluent. It makes serving in free clinics or providing pro bono patient care a core value of our profession. Any system of health care delivery must meet the test of the adherence to these principles or society will suffer.

The emergence of the managed care industry, which now is the model for the delivery of medical care to over half of the nation’s citizens and in some areas approaches an 85 percent market penetration, has posed vexing problems for physicians, their patients, and third-party payers whether private or governmental. Managed care, in all its variations, combines the business of the insurance industry with the delivery of professional health services.

**Discussion**

Fee-for-service arrangements prevailed as the preferred vehicle for financing health care services since World War II. As employers began to offer health insurance, premiums were fixed in such a way that most patients did not bear the full cost of their health care. As employer premiums rose to meet the escalating cost of health care services, efforts by government, business and the insurance industry focused on controlling utilization and reducing health care costs. Group health cooperatives were formed as early precursors of the modern health maintenance organization.

As managed care became more widespread, methods of cost containment became more prevalent by defining medical necessity, coverage policies, practice guidelines, practice profiling, and risk-sharing arrangements. Capitation, as a method of risk sharing, provided new ethical dilemmas in medical decision making. Fee-for-service reimbursement presented ethical challenges by assuring reimbursement for utilization of services and procedures that were ordered for the health benefit of the patient. Economic benefit is derived by the facility and the providers of health care services, while the insurer incurs the financial risk and cost of a fee-for-service system. These costs were typically shifted to the purchasers of health care services, such as employers and the government.

Capitation, in contrast, is defined as the payment of a fixed sum per patient per unit of time. Regardless of how the payment is distributed, the capitation sum is applied to cover the costs incurred in providing a pre-determined set of services to a pool of capitation patients. By providing a fixed budget with which to treat a pool of patients, physicians are motivated to minimize health care costs. The risk of not doing so is that the fixed budget agreed to in the capitation arrangement may not cover the cost of providing care to the capitation pool of patients, and therefore the health care providers bear the financial risk.

Capitation arrangements pose an ethical challenge through the risk-sharing model of encouraging economic incentive via reduced utilization of services, to the financial benefit of the physician and the managed care organization that share the risk. While some applaud the inherent incentive within the capitation risk-sharing system to increase efficiency and reduce over-utilization of resources, others suggest that there exists within a capitation system the insidious incentive to
under treat patients and avoid patients with chronic or extreme illnesses.

A managed care organization's priority is to provide medical necessary care to individuals in the context of limited, controlled resources and population-based rationing decisions. The ethical framework for such rationing decisions must balance concerns for patient autonomy and justice, providing for the judicious and equitable use of distribution of resources.

The widespread implementation of capitation, as an integral part of the attempt to reduce or stabilize the cost of health care, creates an ethical dilemma for the medical profession that has never been faced before. Moreover, the expansion of a pre-payment methodology that shares the cost of treatment risk between the managed care organization and the physician has impacted with noteworthy speed the fundamental relationship between the physician and the patient. The inclusion of the managed care organization into the social contract for health care services creates a wedge between the physician and the patient, that being the fiduciary considerations of the physician on behalf of those sharing the risk, whether they share physicians or the managed care organization. The physician's dilemma of "serving two masters" can result. Capitation poses a definitive dilemma--the constant choice between cost-efficient service and medically necessary treatment.

Legislation primarily at the state level has attempted to negate some of the more blatant transgressions that managed care systems have posed, such as gag clauses in contracts, and requirements of economic credentialing by hospitals and health care plans. These legislative attempts have met with limited success.

As a society, we have a right to determine what amount of gross domestic product (GDP) should be allocated to health care by the purchase of private insurance with premium dollars, and the appropriation of tax revenue for the care of indigent citizens. There is no consensus at this time as to what that percentage of GDP should be.

The American Medical Association (AMA) Council on Ethical and Judicial Affairs provided a report in June 1997, “The Ethical Implications of Capitation.” That report suggests methods of mitigating the ethical concerns of a capitation plan through the following policy statement and recommendations:

**E-8.051 Conflict of Interest Under Capitation**

The application of capitation to physicians' practices can result in the provision of cost-effective, quality medical care. It is important to note, however, that the potential for conflict exists under such systems. Managed care organizations and the physicians who contract with them should attempt to minimize these conflicts and to ensure that capitation is applied in a manner consistent with the interests of patients.

1) Physicians have the obligation to evaluate a health plan's capitation payments prior to contracting with that plan to ensure that the quality of patient care is not threatened by inadequate rates of capitation. Capitation payments should be calculated primarily on relevant medical factors, available outcomes data, the costs associated with involved providers, and consensus-oriented standards of necessary care. Furthermore, the predictable costs resulting from exiting conditions of enrolled patients should be considered when determining the rate of capitation. Different populations of patients have different medical needs, and the costs associated with those needs should be reflected in the per-member per-month payment. Physicians should seek agreements with plans that provide sufficient financial resources for all necessary care, and should refuse to sign agreements that fail in this regard.

2) Physicians must not assume inordinate levels of financial risk, and should therefore consider a number of factors when deciding whether or not to sign a provider agreement. The size of the plan and the time period over which the rate is figured should be considered by physicians evaluating a plan, as well as in determinations of the per-member per-month payment. The capitation rate for large plans can be calculated more accurately than for
smaller plans because of the mitigating influence of probability and the behavior of larger systems. Similarly, length of time will influence the predictability of patient expenditures and should be considered accordingly. Capitation rates calculated for large plans over an extended period of time are able to be more accurate and therefore preferable to those calculated for small groups over a short time period.

3) Stop-loss plans should be in effect to prevent the potential of catastrophic expenses from influencing physician behavior. Physicians should ensure that such arrangements are finalized prior to signing an agreement to provide services in a health plan.

4) Physicians must be prepared to discuss with patients any financial arrangements that could impact patient care. Physicians should avoid reimbursement systems that cannot be disclosed to patients without negatively affecting the patient-physician relationship.

Conclusion

The Academy recognizes the need to control national health care costs, while maintaining quality care. However, it is the view of the Academy that the four basic tenets of ethical medical practice are in serious jeopardy under capitation. The ability of physicians to deliver optimal care to their patients is constantly threatened. The ability of legislation, such as through a “patient bill of rights,” may offer some protection. However, the best safeguard for patients and physicians will be the need for total transparency; that is, the patient must be fully informed as to the terms of the contract which governs the physician’s ability to treat the patient, provide services, and to some extent make clinical decisions. The Academy supports the recommendations of the AMA Council on Ethical and Judicial Affairs Report, “Ethical Implications of Capitation” (June 1997). The Academy further concludes that by maintaining the four tenets of non-maleficence, beneficence, autonomy, and distributive justice as the foundation on which physicians function, physicians hold to an honorable medical profession that will not jeopardize the trust and confidence of the public who are served.

References


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Approved by the Board of Directors 3/10/00
CONTEMPORARY ISSUES: CONFLICT OF INTEREST*

Concern about and scrutiny of conflict of interest issues by regulatory bodies such as the Accreditation Council for Continuing Medical Education (ACCME), American Association of Medical Colleges (AAMC), Office of the Inspector General (OIG), and Congress have intensified over the past year. In recent years the medical and lay media has highlighted failures of individuals and institutions to disclose and appropriately manage financial ties with industry. The public, the regulatory bodies, and, for professional associations, the members, expect no less than complete transparency and objectivity. As medical research, professional education, health care, and institutional management have become vastly more complex and expensive, the task of managing conflicts of interest has become more challenging. 1-11

The Institute of Medicine (IOM) has undertaken the task of coordinating a variety of associations involved in health care and education and will conduct six meetings throughout 2008 to hear testimony on this issue. By early 2009, the IOM will prepare a consensus report that provides guidelines for addressing conflicts of interest.7

All of medicine is being sensitized about the real and perceived effect relationships may have on decisions and actions of individuals and organizations. Frequently the discussion about conflict of interest focuses on a financial interest, but other forms of interest can raise conflicts as well, such as membership in another organization, having a family member with a significant conflicting relationship, or having an emotional attachment to an organization or cause.

Organizations operate best in a climate of trust, openness, and objective decision-making, believing that all involved are putting the interests of the organization and its members first. This is also part of the fiduciary responsibility of elected and appointed leaders.

Every individual is influenced by relationships that color opinions, behavior, and participation in group discussions and decision-making. The simple existence of a relationship is not categorically improper. Recognizing a potential conflict because of that relationship and managing it are essential to achieving an unbiased outcome in an organization.

Recognizing relationships and managing them can be a difficult process. The disclosing individual and the audience may have differing opinions about whether a relationship is material. It is not possible, nor is it necessary, to eliminate all perceived, potential, or real conflicts of interest but it is in the best interests of the organization and the public to effectively acknowledge and manage potential conflicts. The existence of a potential conflict is not necessarily a problem; it is how individuals and institutions respond to potential conflicts that may be problematic. An essential requirement for achieving objective discussion and decision making is to foster a culture that encourages open discussion of the issues when they arise. Everyone needs to take responsibility for establishing a climate of objectivity, but those in positions of authority can set the tone, welcome open discussion, and push for a resolution of a potential bias.4

Definition

A generally accepted working definition of a conflict of interest is a situation in which financial or other personal considerations have the potential to compromise or bias judgment and objectivity. While conflicts of interest apply to a wide range of behaviors and circumstances, they all involve the use (or potential use) of a person’s authority for personal and/or financial gain rather than the best interests of the organization. For professional associations, conflict of interest is often defined as the situation where a personal or financial interest conflicts with the objectives and purposes of the association as set forth in its bylaws.
Examples of Possible Conflicts of Interest

Examples of conflicts which could result in placing one's self-interest or a third-party interest above that of the association include:

- Introducing or advocating for an activity for discussion and action that would benefit an individual's own company or other organization in which the individual has a personal or financial interest, whether or not it is consistent with the mission of the Academy
- Using Board membership or an association's resources for personal or third-party gain or pleasure
- Unfairly taking advantage of an authoritative position to affect the commercial or professional standing of a company or organization in which an individual has a personal financial interest or that is a competitor
- Using information made available because of an individual's position that is proprietary or confidential or otherwise not generally known to the public for personal advantage
- Accepting a service, discount, concession, fee for advice or other thing of value from a person or organization with an interest in an issue or transaction under discussion by the Academy
- Withholding disclosure of relationships with industry, institutions, and other organizations.
- Presenting unsupported information or data that has been biased or unduly influenced by a personal or financial relationship
- Participating in discussions on policy issues relating to other professional organizations in which the individual has a fiduciary position
- Spouses or other first-degree relatives (children, parents, and siblings) who are executives or have an interest in other organizations or companies

Disclosure

Conflicts of interest must be recognized, identified and resolved. Disclosure of all relationships with the potential to bias judgment is the first step for the person and the audience to become aware of the influence these relationships may have on decisions, discussions, or actions. Often disclosure of the conflict or potentially conflicting interest will protect the integrity of the situation. Once disclosed, the other participants will be able to evaluate and adjust for the possible influence of the disclosed interest. Disclosure may not suffice. Appropriate resolution of actual, potential and apparent disclosures is necessary to ensure objective discussion and decision-making.

Resolution Beyond Disclosure

The disclosing individual, the oversight individual or group, and the audience all have responsibilities in managing and resolving actual or potential conflicts of interest for which disclosure is not sufficient. In such circumstances, the disclosing individual should take action, on his or her own, to manage the conflict through recusal or resignation. Ultimately, the organization is responsible for resolving the conflict, whether through recusal or resignation. An actual, potential or apparent conflict of interest for which disclosure does not suffice may be resolved in one of the following manners:

- Recuse the individual from all decision-making related to the relevant transaction which gives rise to the conflict, but allow the individual to participate in discussion and deliberations on the transaction.
• Recuse the individual from all discussion, deliberations, and decision-making related to the relevant transaction which gives rise to the conflict.

• Determine that the individual has a pervasive and continuing conflict and, therefore, must resign his or her position with the organization.

Academy Policies and Procedures

The American Association of Society Executives Web site notes the high priority of the conflict of interest issue with the associations it represents. The American Medical Association (AMA) published conflict of interest guidelines for medical societies in 1999 that are still applicable. The American Academy of Dermatology (AAD) has also adopted guidelines that are consistent with the AMA document.

The AAD Board of Directors and any appointees of the Academy must act at all times in the best interests of the Academy and not for personal or third-party gain or financial benefit.

The American Academy of Dermatology has long understood the need for comprehensive disclosure policies and first developed an Administrative Regulation (AR) on Policy and Procedures Regarding Actual or Potential Conflicts of Interest3 to reflect its perspectives twenty years ago. This AR, which was initiated in 1988, has been revised as recently as April 2007 [see AR at www.aad.org]. The AR states that “it is important that Academy decisions and actions not be unduly influenced by any special interests of individual members.”

The language in the disclosure form that all individuals within the AAD governance structure must sign annually states “I occupy a position of trust and that I am expected to act at all times in good faith and without bias or favor to outside interests. Whenever my outside interests or other responsibilities potentially conflict with my duty to the Academy, I will declare these potential conflicts and will act in such a manner as to avoid even the appearance of using my position to advance any personal interest or the interest of any individual or entity with whom I have a significant relationship. In particular, I will not act in a way inconsistent with the purposes and interest of the Academy”.

The AAD is committed to clarity and transparency in our conflict of interest policies, especially in the areas of governance, education, and scientific publication. All individuals in the Academy governance and educational structure are required to disclose their and their first-degree relatives’ relationships with industry, employers, other associations or any other organization that could create a private interest in conflict with the Academy’s interest. Comprehensive disclosure forms are maintained in the Academy's offices and on the Academy’s Web site. Disclosure statements are circulated prior to any meeting or educational activity for viewing by attendees or participants. The opportunity to review or update disclosure statements is provided at the beginning of each session.

As the current administrative regulation states, for determining whether actual, potential or apparent conflict could prevent service to the Academy, Council chairpersons review their constituent members’ disclosure statements. If any appear to have conflicts that could prevent them from serving, they are forwarded to the Secretary-Treasurer with any relevant observations or recommendations. The Secretary- Treasurer reviews the statements submitted and if further review is required, forwards the statements to the Ethics Committee. The Ethics Committee then initiates any request for further information and reports its findings to the Secretary Treasurer and then to the Board of Directors.

As the AR currently states, “Because proper disclosure by each individual author, speaker or Academy leader is essential if the system is to function satisfactorily, it is important for everyone involved to approach with the proper perspective the question of what types of circumstances call for disclosure. The purpose of the procedures is not to discourage all involvement by Academy members in outside activities which might produce actual or potential conflicts with interests of
the Academy. Neither is the objective to intrude into aspects of an individual's professional or personal life which are, realistically, unlikely to have any significant bearing on Academy activities. Common sense should guide all decisions about what to disclose, and one reasonable test is whether a particular circumstance, interest or relationship, if made known to the full membership of the Academy or to the general public, would be likely to cause embarrassment for the Academy and/or the individual involved or evoke suspicion about the motives behind any Academy action."

The Academy is dedicated to providing continuing medical education that is independent, fair, balanced, objective and free of commercial bias. The Academy AR also applies the same standards of disclosure and avoidance of actual, perceived or potential conflicts of interest to authors of Academy publications and speakers at Academy educational meetings. Comprehensive disclosure, review by editors and oversight panels, and resolution of conflicts by directors and editors are essential steps in assuring the fair and balanced presentation of scientific information.

Summary

Academy members in leadership positions should understand that they occupy a position of trust and are expected to act at all times in the best interests of the Academy, in good faith, and without bias or favor to outside interest. Whenever outside interests or other responsibilities potentially conflict with duty to the Academy, these must be declared. Members certify that they will act in such manner as to avoid even the appearance of using positions to advance any personal interest. If an actual, potential, or apparent conflict is detected, policies are in place to resolve such conflicts. All authors of Academy publications and speakers at Academy meetings adhere to the same principles of disclosure and avoidance of conflict of interest for the fair and balanced presentation of scientific information that guides practice. Any member who speaks at the Annual Business Meeting or Advisory Board Meeting must verbally disclose any potential conflicts of interest before speaking. The Academy is committed to transparency and objective decision-making at all organizational levels.

Resources on COI


6. Association of American Medical Colleges (AAMC) and Association of American Universities: Protecting Patients, Preserving Integrity, Advancing Health: Accelerating the Implementation of COI Policies in Human Subjects Research (calls on all medical schools and major research universities to develop and implement institutional financial conflicts of interest (COI) policies within the next two years, and to refine standards for addressing individual financial COI), 2008, http://www.aamc.org.

The Institute of Medicine has undertaken the task of coordinating a variety of associations involved in health care and education and will conduct 6 meetings throughout 2008 to hear testimony. The IOM will prepare a consensus report that will:

1. examine and describe conflicts of interest involving health care professionals and industry in different contexts, including, for example, the conduct of research, the education of health professionals, the development of practice guidelines, the provision of patient care, and the management of academic and other institutions;

2. propose principles to inform the design of policies, guidelines, and other tools to identify and manage conflicts of interest in these contexts without damaging constructive collaboration with industry; and

3. consider methods to disseminate, promote, implement, and evaluate these principles and policies.


*Approved by the American Academy of Dermatology Executive Committee, 7/10/08 and the AAD Board of Directors, 8/2/00

**Position Statement on the Definitions of Cosmetic and Reconstructive Surgery**

The American Academy of Dermatology supports the American Medical Association’s definitions of “cosmetic” and “reconstructive” surgery, which read as follows: H-475.992 Definitions of “Cosmetic” and “Reconstructive” Surgery

(1) **The AMA supports the following definitions of “cosmetic” and “reconstructive” surgery:** Cosmetic surgery is performed to reshape normal structure of the body in order to improve the patient's appearance and self-esteem. Reconstructive surgery is performed on abnormal structures of the body, caused by congenital defects, development abnormalities, trauma, infection, tumors or disease. It is generally performed to improve function, but may also be done to approximate a normal appearance.

(2) **The AMA encourages third-party payers to use these definitions in determining services eligible for coverage under the plans they offer or administer.** (CMS Rep. F, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed, A-03)

*Approved by the Board of Directors 5/13/95, 1995; 8/7/10*
Position Statement on Dispensing

Dermatologists should not dispense or supply drugs, remedies or appliances unless it is manifestly in the best interest of their patients.

Dermatologists who dispense in office should do so in a manner with the best interest of their patient as their highest priority, as it is in all other aspects of dermatologic practice.

It is ethical to dispense, by sale, prescription or non-prescription drugs, to patients in a dermatologist’s office except in the following circumstances:

1. When the dermatologist places his/her own financial interests above the welfare of his/her patients.
2. When creating an atmosphere which is coercive to patients such that they feel compelled to purchase drugs from the dermatologist.
3. When dispensing drugs under a dermatologist’s private label without clearly listing the ingredients, including generic names of the drugs.
4. When dispensing to patients drugs which are easily available at proprietary pharmacies without advising patients of this availability.
5. When representing drugs as being a special formula not elsewhere available, when that is not the case.
6. When selling health-related products whose claims of benefit lack validity.
7. When refusing to give refills of drugs except that they be purchased from the dermatologist.
8. When charging patients at an excessive mark-up rate.

Approved by the Board of Directors 10/12/98, 9/26/99
Position Statement on Expert Witnesses

The integrity of the judicial process depends, in part, on the honest, unbiased testimony of expert witnesses on both sides of courtroom controversies. Justice, humaneness, and professionalism demand that dermatologists bring to the courtroom the same competence, expertise, objectivity, and compassion that they bring to the care of their patients; testimony in matters medical/legal is as much a part of the practice of medicine as is caring for patients.

Witnesses are designated as “expert” if they have knowledge of specific topics thought to be beyond the ready understanding of the laity. Non-partisan, scientifically valid expert testimony assists soundly in the deliberation of particular cases and contributes to equitable outcomes based on generally accepted medical principles. The expert witness is expected to be impartial and should not assume the role of advocate except as a spokesperson for the field of special knowledge that he or she represents.

It is unethical to request or to accept a fee that in any way is contingent on the outcome of any judicial proceeding. Compensation of the expert witness should be reasonable and commensurate with the time and effort devoted to preparing for, and attending, depositions and court proceedings.

In order to warrant designation as an expert witness, a dermatologist serving as an expert witness should be licensed to practice medicine, certified by the American Board of Dermatology, should be engaged in the active practice of medicine and be able to demonstrate familiarity with current standards of practice in the arena pertinent to his or her testimony, as well as with standards of practice prevailing at the time of the matter at issue. A physician should never testify concerning matters about which he or she is not knowledgeable.

Prior to offering any testimony, a dermatologist serving as an expert witness should:

- Become familiar with all data relevant to the particular matter at issue, excluding no relevant information for the purpose of creating a view that favors either party to a dispute;
- Review previous and current concepts related to standards of dermatologic practice standards applicable to the matter at issue;
- Decide whether his or her opinions, if any, will contribute in a meaningful, positive, and unbiased way to adjudication of the case impartially.

The expert witness should:

- Testify honestly, fully, and impartially concerning his or her qualifications as an expert.
- Offer expert testimony that is objective, truthful and accurate, based solely on medical knowledge of the matter at issue and never on the litigation posture of plaintiff(s) or defendant(s).
- Offer an assessment of the matter at issue in the context of generally accepted standards of practice, neither condemning performance that clearly falls within generally accepted standards of practice nor endorsing or condoning performance that clearly falls outside accepted standards of practice.
- Honestly, and fully, describe where and how his or her opinions may differ from common practice, never representing his or her own views as the only correct ones if they differ from those held by other qualified dermatologists.

These principles apply equally to pretrial evaluation of medical/legal disputes, whether or not such opinion is given under oath. The expert witness should be aware that depositions and courtroom testimony are public statements. The physician expert should not offer testimony that he or she would not be willing to submit for independent peer review.

Approved by the Board of Directors November 22, 2003
Position Statement on Isotretinoin

1. The Association is committed to the safe and responsible use of isotretinoin. Isotretinoin is FDA approved for and generally considered by dermatologists to be the most effective treatment for severe recalcitrant nodular acne. The effectiveness of systemic isotretinoin therapy in the treatment of acne has been demonstrated in randomized, double blinded clinical studies. It is known to effectively reduce acne and lead to a reduction in scarring. 1-4

2. The Association recognizes there is sufficient evidence for the use of isotretinoin in severe forms of acne, particularly (but not limited to) severe recalcitrant nodular acne or acne which has proven refractory to other forms of therapy. Assessment of severity includes the impact of the disease on the patient, both physical and psychological.1

3. The Association recognizes that isotretinoin has been used off-label in the treatment of conditions such as disorders of cornification and in chemoprevention of skin cancer in high risk individuals. The Association believes such off-label uses are permitted under the FDA’s “practice of medicine” exception to its drug approval process. Physicians considering the use of isotretinoin in such off-label indications should make the patient aware that off-label usage has not been specifically approved by FDA.

4. The Association promotes compliance with the manufacturer-sponsored and FDA-approved risk management program for prescribing isotretinoin (iPLEDGE). It opposes on-line Internet dispensing, sharing, or use without physician supervision, because these activities do not provide for sufficient patient education about isotretinoin risks and do not require participation in the iPLEDGE program.

5. The Association supports continuing education for physicians, their office staff, allied medical personnel, and patients on the potential risks connected with the use of isotretinoin. In particular, prescribers, patients, pharmacies, and manufacturers must comply with the iPLEDGE risk management program as outlined on the iPLEDGE web site (www.i pledgeprogram.com) to prevent fetal exposure during treatment with isotretinoin.1

6. A correlation between isotretinoin use and depression/anxiety symptoms has been suggested but an evidence-based causal relationship has not been established. Other studies give evidence that treatment of acne with isotretinoin was accompanied by improvement of both depressive and anxiety symptoms, as well as improved quality of life of patients with acne. 1 5 6

7. Current evidence is insufficient to prove either an association or a causal relationship between isotretinoin use and inflammatory bowel disease (IBD) in the general population. 7, 8 While some recent studies have suggested such a relationship 9,10, further studies are required to conclusively determine if the association or causal relationship exists and/or whether IBD risk may be linked to the presence of severe acne itself.

8. The Association concludes that the prescription of isotretinoin for severe nodular acne continues to be appropriate as long as prescribing physicians are aware of the issues related to isotretinoin use, including IBD or psychiatric disturbance, and educate their patients about these and other potential risks. Physicians also should monitor their patients for any indication of IBD and depressive symptoms.
References


10. Crockett SD, Porter CQ, Martin CF, Sandler RS, Kappelman MD. “Isotretinoin Use and the Risk of Inflammatory Bowel Disease: A Case-Control Study.” Am J Gastroenterol. 2010 Mar 30 online

Approved by the Board of Directors 12/9/00; 3/25/03; 3/11/04; 11/13/10
Position Statement on Medical Spa Standards of Practice

This position statement establishes standards of practice for the performance, delegation, assignment, and supervision of medical and surgical procedures performed by a physician or non-physician under a physician's direction at a medical spa facility.

Medical spas are facilities that offer a range of services, including medical and surgical procedures, for the purpose of improving an individual's well-being and/or appearance. The distinguishing feature of medical spas is that medicine and surgery are practiced in a non-traditional setting.

Procedures by any means, methods, devices, or instruments that can alter or cause biologic change or damage the skin and subcutaneous tissue constitute the practice of medicine and surgery. These include but are not limited to the use of: scalpels; all lasers and light sources, microwave energy, electrical impulses, and all other energy emitting devices; thermal destruction; chemical application; particle sanding; and other foreign or natural substances by injection or insertion.

Any procedure that constitutes the practice of medicine, including but not limited to any procedure using a Food and Drug Administration (FDA)-cleared or regulated device that can alter or cause biologic change or damage, should be performed only by an appropriately-trained physician or appropriately-trained non-physician personnel under the direct, on-site supervision of an appropriately-trained physician in accordance with applicable local, state, or federal laws and regulations.

The optimal quality of medical aesthetic care is delivered when a qualified and licensed physician provides direct, on-site supervision to all qualified and licensed non-physician personnel. On-site supervision means a supervising physician that is both present at the site and is able to respond immediately, in-person, during a delegated or assigned medical aesthetic procedure. Each medical spa facility should maintain up-to-date written procedures regarding appropriate delegation and supervision protocols for all medical aesthetic procedures performed within the facility.

A medical director of a medical spa facility should be clearly identified by licensure, medical specialty, training and education, as the medical director in all marketing materials and Internet Web sites related to the medical spa facility. If marketing materials mention a physician's board-certification, the certifying board and specific specialty should be stated, e.g., Diplomate of the American Board of Medical Specialties (ABMS) in Dermatology. Furthermore, the medical director shall ensure that marketing and advertising materials of a medical spa facility do not include false, misleading, or deceptive representations.

A medical director shall be ultimately responsible for all acts personally delegated or delegated by an assigned supervising physician to non-physician personnel in a medical spa facility. A medical director or supervising physician is responsible for performing an initial assessment of each patient in a medical spa facility, preparing a written treatment plan, obtaining informed consent from all patients including disclosure of personnel performing the procedure(s), creating and maintaining patient medical records in accordance with local, state and federal laws and regulations, and reviewing all patient charts. Any adverse events that occur as a result of the performance of a medical aesthetic service must be reported immediately to the facility's medical director and supervising physician.

Any physician or non-physician personnel who provide medical aesthetic care must be qualified to:

1) perform such services by virtue of having received appropriate theoretical and clinical instruction and training in each service to be performed including safety, clinical application, pre- and post-procedural care; and 2) handle any resultant emergencies or sequelae.

Any licensed physician or non-physician employed by a medical spa facility, including a medical director, must have received appropriate documented training and education in the safe and effective performance of all medical aesthetic services performed in the facility. Continuing medical education of all licensed medical professionals should be mandatory and repeated with reasonable frequency to help ensure maximal proficiency. This docu-
mented training and education must be readily available to the public and must include instruction in the use of all FDA-cleared or regulated products or devices used or provided by the medical spa facility.

Medical spa facilities should be licensed and inspected on a regular basis to ensure compliance with all applicable federal and state laws. Medical spa facilities must be able to prove they have the necessary personnel, equipment and protocols to safely perform all offered procedures and handle any emergencies or sequelae that may arise. Any incident within the medical spa facility that results in a patient death, transport of the patient to the hospital, or a significant complication or adverse event requiring additional medical treatment, shall be reported to the appropriate state agency, the FDA if cleared or regulated devices were involved, or both. Medical spa facilities, medical directors, and all non-physician personnel shall maintain appropriate liability insurance or communicate lack of insurance in advance to all patients.

Patient health and safety is paramount and should not be compromised in the interest of financial gain. Therefore, owners and employees of medical spa facilities who are not licensed to practice medicine shall not exercise control over an employed physician's medical judgment or engage in decisions related to patient care and/or the performance of medical aesthetic services.

This Position Statement is intended to offer guiding principles regarding the practice of medicine and surgery in medical spa facilities. This Position Statement is not intended to establish a legal standard of care.

Approved by the Board of Directors: 5/7/11

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**Position Statement on Pathology Billing**

Dermatologists, based on their education and training, should be permitted to interpret pathology specimens. No single specialty has exclusive rights to utilize and bill for individual CPT codes.

When dermatologists choose to send pathology specimens out for interpretation, they should be able to choose the laboratory and/or dermatopathologist they believe is best for their patients.

Dermatologists are entitled to fair compensation for their own dermatopathology services.

Dermatologists should not charge for dermatopathology services rendered by other providers except in situations where:

1. The patient is made aware of the charge by an outside laboratory or consultant performing the service; and

2. Any added charge is reasonable and commensurate with professional or administrative services personally rendered by the dermatologist and/or his/her practice and does not violate federal or state laws.

CPT Codes 88304 and 88305 represent a particular service personally performed by a physician. As such, dermatologists purchasing dermatopathology services from an outside source should not use codes 88304 or 88305 for billing purposes without the modifier -90 as an indication that the service was provided by an outside laboratory. Further, the outside laboratory should be appropriately indicated on the claim form.

Dermatologists and their staff need to be aware of, and comply with, the full scope of complex federal and state laws and regulations governing billing of pathology laboratory services.

This Position Statement is intended to offer physicians guiding principles regarding anatomic pathology billing practices. This Position Statement is not intended to establish a legal standard of care.

Approved by the Board of Directors: 5/20/06; 5/8/07; 8/5/07; 2/5/11
Position Statement on Patient Access to Specialized Medical Services Under Health Care Reform

Background:

The US health care system currently provides prompt and direct access to medical and surgical specialists for the vast majority of the population. Health care reform may place limits on the access and patient freedom of choice. Some limits or controls may be appropriate, others may not.

Health care reform legislation, however, should not set barriers or impediments to appropriate specialized medical services. The patient’s first point of contact should be encouraged to make all needed medical referrals and should not feel constrained financially from doing the best job for the patient. Patients should also be able to opt out of any closed system to seek the specialist of choice. The financial penalties that accrue to such an opt out, or “point of service” should be capped. This option is the ultimate consumer protection against poorly managed health care plans.

Direct access to specialty care is essential for patients in emergency and non-emergency situations, and for patients with chronic and temporary conditions, as well as those with unexpected acute care episodes. Specialty care must be available for the full duration of the occurrence, and not limited by time or number of visits.

Specialization, specialized training, and specialized care have produced the great leaps that have taken place in medicine, and have resulted in the development of life-saving and life-enhancing procedures.

Recommendations:

Health care reform legislation should encourage appropriate utilization of medical and surgical specialists by assuring that following elements are incorporated in the bill:

Financial incentives should not interfere with medical judgment. For instance, health plans should be prohibited from establishing arrangements in which the gatekeeper has a financial incentive to not refer patients. Laws should be enacted to protect patients from under-referral for financial gain.

Point of service options should be mandatory for all plans with limitations on out-of-pocket expenses to patients. A point of service option that is financially prohibitive is not an option.

All health plans must establish arrangements to provide the full range of specialized care for enrollees with rare, unusual, or highly complex conditions, and should provide all specialty services not generally regarded as experimental.

Medical and surgical specialty societies should be responsible for the development of guidelines on the appropriateness of referrals.

All health plans should be evaluated in a consumer “report card” in part on the basis of the timeliness of access to specialty care and the quality of the care as established through the credentials of the physicians and the outcomes of their treatments.
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**PATIENT ACCESS TO SPECIALTY CARE COALITION**

317 Massachusetts Ave, NE, First Floor ● Washington, DC 20002

Telephone: (202) 546-4732 ● Fax: (202) 546-5051

*Approved by the Board of Directors 3/94*
Position Statement on Photographic Enhancement

Photographic documentation of skin diseases and their response to therapy is an established tradition in dermatology. In scientific reports, representational images are synonymous with data and subject to the same rules of ethical scientific conduct. They should be acquired and presented in an objective, accurate and unbiased manner. As in collecting any data, the technology used can influence the results obtained. This is true for traditional photographic techniques and processing, and more recently for digital manipulation of electronically captured, processed, or rendered images. Use of these technologies to misrepresent or alter the scientific content of an image for purposes of promoting one result or interpretation over another is unethical.

The American Academy of Dermatology (AAD) shall adhere to the highest scientific and ethical standards in all of its presentations of medical and dermatologic information, including images, to professionals and the public. This rule shall apply to the Academy’s scientific meetings, printed journals, electronic publications and resources, an educational products and offering. Objective balanced and unbiased presentation of data, including images, is expected and required of all participants in AAD scientific and educational activities, whatever the venue. Similar ethical and professional behavior is expected of AAD members in all of their individual professional activities.

Authors of articles in AAD publications, presenters at AAD-sponsored meetings, or those otherwise acting on behalf of AAD or its affiliates, should make all reasonable efforts to obtain an objective and accurate original image that portrays an entity with fidelity. “Before” and “after” images should be obtained under identical (similar) reproducible conditions. The fidelity and scientific content of the original image should be retained in the final published or presentation medium. Manipulations (e.g. cropping, contrast, color balance, etc.) to properly and accurately prepare an image are acceptable practices. Image manipulation with the intent to enhance, expunge, diffuse, alter, or misrepresent its scientific data content is unethical and will not be tolerated. An original transparency, negative, or electronic file of the image must be maintained and made available to the AAD or its affiliates upon request.

All images that have been manipulated by any means must carry a disclaimer when submitted to the AAD for use in its activities. An image that has been manipulated to alter extraneous non-scientific content of material (e.g. deleted background objects), without altering its scientific content, is acceptable, provided that a disclaimer is attached to the image detailing specifically what was done and why it was done. Acceptability of images for purposes of AAD activities remains the sole prerogative of the AAD. Photographically or electronically manipulated or rendered images must bear a symbol in the lower right hand corner (“E” or similar notation), denoting that the image has been altered. If questioned, presenter must accurately explain how the image was altered and how it differs from its original.

Approved by the Board of Directors 8/2/97; 8/5/07
Position Statement on Physician Financial Incentives

Financial incentives are now common features in physician employment agreements with managed care organizations. These incentives generally take the form of bonuses or holdbacks. In the health care marketplace, particularly in managed care settings, financial incentives raise concerns of conflict of interest. Because financial conflicts of interest can adversely affect patient care, the American Academy of Dermatology is opposed to any financial incentive that directly or indirectly reduces or limits medically necessary services to patients.

In evaluating a financial incentive, the relationship between the physician's primary duty and the financial incentive is the main consideration. A physician's principal responsibility is providing quality patient care. We must ensure that patient care and medical judgment are not compromised or do not appear to be compromised by any financial incentive. Physicians must not deny their patients access to appropriate services based upon the promise of personal financial gain or the avoidance of financial penalties. Financial incentives must not interfere with medical judgment and patient care.

A health insurance plan's failure to disclose any financial conflicts of interest at the time of enrollment is inappropriate and fraudulent. Patients must have the necessary information to make informed decisions about their health care. Health insurance plans have an ethical obligation to disclose to patients any restrictions on referrals or treatment options.

Above all, the physician must have the patient's best interests at heart when treating the patient or discussing treatment options. Our contract has always been, and should forever remain, one between the patient and physician.

Approved by the Board of Directors 3/21/97; 7/39/26
Position Statement on The Practice of Dermatology: 
Protecting and Preserving Patient Safety and Quality Care

The guiding principle for all dermatologists is to practice ethical medicine with the highest possible standards to ensure that the best interests and welfare of each patient are guaranteed.

The Practice of Dermatology (Cutaneous Medicine)
The practice of dermatology includes, but is not limited to, diagnosis, treatment, or correction of human conditions, ailments, diseases, injuries, or infirmities of the skin, hair, nails and mucous membranes, by any medical, surgical, pathologic or aesthetic means, medications, methods, devices, or instruments. These conditions may be primary cutaneous ailments or part of a systemic disease.

The practice of dermatology includes, but is not limited to, performing any act or procedure that can alter or cause biologic change or damage to the skin and subcutaneous tissue.

Any procedure using any approved device that can alter or cause biologic change or damage, should be performed only by an appropriately trained physician or non-physician personnel under the direct, on-site supervision of an appropriately trained physician.

The practice of dermatology, in accordance with this position statement, can occur in varied settings. The highest level of standards to practice dermatology should be applied across all settings.

Who is a Dermatologist?
A dermatologist is a licensed medical doctor and the only residency-trained physician specialist fully educated in the science and art of cutaneous medicine, which includes the medical, surgical, pathologic and aesthetic conditions of the skin, hair, nails, and mucous membranes, and who is eligible for board certification from the American Board of Dermatology, the Royal College of Physicians and Surgeons of Canada, or the American Osteopathic Board of Dermatology.

A dermatologist must have an extensive understanding of cutaneous medicine, surgery, and pathology. Patients receive the highest quality dermatologic care when their care is provided by a dermatologist with specialized medical training and expertise. The delivery of dermatologic services by a non-dermatologist or unsupervised non-physician personnel is limited and may result in a higher incidence of adverse events, complications, or suboptimal results.

Those who regulate and deliver medical care have an obligation to inform the public of the qualifications and limitations of those who provide their dermatologic care. All personnel working in a dermatologic setting should identify or disclose their board-certification (if any) and/or licensure to each patient. This could be disclosed verbally or displayed prominently in writing.

Training & Education
A dermatologist is ultimately responsible for the care and safety of patients in his or her practice.

At certain times, and under the direction of a board-certified dermatologist, the practice of dermatology requires a team approach and may include other providers practicing in a dermatologic setting, including but not limited to: non-dermatologist physicians; advanced practitioners; allied health professionals; licensed personnel; and other personnel.

Training of all personnel should be commensurate with their licensure and/or experience and the degree of difficulty or complexity of the medical care, diagnoses, treatments, procedures/techniques, services or tasks being delegated to them by a dermatologist. Optimum practice standards require that a dermatologist maintain written documentation on the training and education received by all personnel to which medical care, procedures/techniques, services or tasks are delegated.

20 Procedures which can alter or cause biologic change or damage the skin and subcutaneous tissue include but are not limited to: the use of all lasers, scalpel, light sources, microwave energy, electrical impulses, chemical application, particle sanding, the injection or insertion of foreign or natural substances, or soft tissue augmentation.
**Delegation & Supervision**

The optimum degree of dermatologic care is delivered when a dermatologist, as defined here, provides direct, on-site supervision to all non-dermatologist personnel. Each practice should maintain written procedures regarding appropriate delegation and supervision protocols for all personnel within the practice.

When practicing in a dermatological setting, non-dermatologist physicians and advanced practice providers such as nurse practitioners and physician assistants, consistent with their appropriate training and experience, should be directly supervised by an on-site dermatologist. In exceptional or extenuating circumstances when a dermatologist is not available on-site written protocols and procedures should provide a mechanism for a patient to be seen by a dermatologist in a timely fashion in person or via teledermatology.

Licensed allied health professionals, including but not limited to registered nurses and licensed practical nurses, when practicing in a dermatological setting, should only provide care after a patient receives an initial evaluation, diagnosis, and treatment plan from a dermatologist. Allied health professionals should be directly supervised by an on-site dermatologist when providing care or performing specific procedures/techniques.

Aestheticians, cosmetologists and electrologists are not legally permitted to engage in the practice of medicine. When practicing in a dermatological setting, these licensed professionals should only perform delegated services after a patient receives an initial evaluation, diagnosis and treatment plan from a dermatologist. These licensed professionals should only perform delegated services under the direct, on-site supervision of a dermatologist.

Licensed and unlicensed medical assistants are not legally permitted to engage in the practice of medicine. Prior to any task being performed by a licensed or unlicensed medical assistant in a dermatological setting, a patient must first receive an evaluation, diagnosis, and treatment plan from a dermatologist. Medical assistants should only assist a dermatologist with specific tasks under a dermatologist’s direct, personal supervision.

The regulatory language governing physician delegation of health care services to non-physician personnel varies greatly from state to state. However, the common theme in state regulations is that physicians may only delegate procedures/techniques or tasks to those individuals that are competent and qualified, by their training, experience, or licensure. In addition, delegated tasks or procedures/techniques must be within the delegating dermatologist’s area of expertise. No care, procedure/technique, service or task should be delegated to personnel who do not possess the proper training and education to perform such care, procedure/technique, service or task.

*This Position Statement is intended to offer physicians guiding principles regarding the practice of dermatology and delegation of these tasks and procedures. This Position Statement is not intended to establish a legal standard of care. Physicians should use their personal and professional judgment in interpreting these guidelines and applying them to the particular circumstances of their individual practice arrangements.*

*Approved by the Board of Directors on 5/22/10*
Position Statement on Prescribing via the Internet, Phone, Facsimile, or Telemedicine

The American Academy of Dermatology (AAD) is aware that health-related information, and prescription and nonprescription products provided to patients by way of the Internet, phone, facsimile (fax), or by telemedicine may offer an opportunity for patients to access health-related products conveniently and privately. However, the provision of prescription pharmaceuticals without an actual face-to-face encounter between a patient and the patient's physician expose patients to risks not encountered when prescription products are provided via the traditional method of visiting a physician. Prescribing without a face-to-face encounter may deny the patient the ability to:

- receive an examination by the physician to determine the patient's history, the medical problem, and a specific diagnosis;
- discuss alternative treatments and determine the best course of treatment; and
- discuss the benefits, risks, and contraindications of the drug to be prescribed.

In addition, in some cases, the patients receiving prescription pharmaceuticals without a face-to-face encounter with a physician may not be provided the benefit of a follow-up visit to assess the therapeutic outcome of the treatment.

Physicians who are deprived the benefits of the patient visit, may lose the ability to establish a reliable, well-discussed medical history. In many cases of online prescription services, the Web site provides online consultation for an additional fee. Frequently the online consultation is conducted via a questionnaire that is completed by the patient. The American Medical Association in June 1999 adopted the position that any health care practitioner who offers prescriptions based solely on the basis on an online questionnaire, without having ever examined the patient, generally has not met the appropriate medical standard of care. The U.S. Food and Drug Administration agreed with this position, and more than a dozen states have taken action against practitioners who prescribe drugs in this manner. The use of online questionnaires offers the patient the increased ability to offer inaccurate or incorrect information. While patients can provide inaccurate or incorrect information to a physician during a face-to-face encounter, the physician has the opportunity to examine the patient, conduct tests, and otherwise evaluate the accuracy of the patient-provided information.

A telemedicine session, as an alternative to a face-to-face visit, provides the physician and the patient with the opportunity for a face-to-face encounter, during which an appropriate physical examination can be conducted, and discussions of alternative treatments, risks and benefits can occur. Telemedicine has the potential to substantially improve access to needed health care services and medical expertise, particularly in under-served areas. Furthermore, the establishment of a patient-physician relationship is accomplished by a telemedicine session. However, a physician providing medical and pharmaceutical services via a telemedicine session to a patient outside the state in which the physician is licensed to practice medicine must be aware of and meet the requirements of the state in which the patient is located. The requirements for “licensing by endorsement,” i.e., granting a license to a physician in another state, vary considerably from state to state. Physicians who provide interstate telemedicine service should be certain they meet the telemedicine requirements in the state where they practice medicine, and in the state in which the patient is located.
Conclusion

In its Board of Trustees Report 35 (A-99), the AMA identified legitimate uses of the Internet, phone, or fax, for prescribing and dispensing. The AAD supports these uses of the Internet. They include:

1. computer entry and online transmission of prescriptions, which is thought by some to be an improvement over handwriting, and a method of decreasing medical errors;

2. ordering refills online, in the cases where the physician does not have to see the patient at the time the refill is ordered, but the patient remains under that physician’s care and has been seen in person in the recent past; and

3. prescribing when the patient is under the physician’s care, the physician has the patient’s history and physical information in the medical record, the patient has been seen in the recent past, and the physician does not need to see the patient at the time a new prescription is ordered. The key is that the patient and the physician have an ongoing relationship, and the patient’s history and physical are in the physician’s medical record.

Because of the concerns suggested in this statement, the AAD opposes offering prescription pharmaceuticals via the Internet, phone or fax, without the benefit of safeguards that ensure that an adequate, recent patient history and physical is taken; that the patient receives full disclosure of the risks, side effects and limitations of the prescribed product; and where appropriate intervention and follow-up are provided to the patient.

References

1. American Medical Association Board of Trustee’s Report 35 (A99), Internet prescribing.

2. American Medical Association Council on Ethical and Judicial Affairs, Physician advisory or referral services by telecommunications (A94), Policy 5.025.


Approved by the Board of Directors 6/4/00
Position Statement on Truth in Advertising & Professional Credential Disclosure

The American Academy of Dermatology Association (AADA) strongly recommends the implementation of direct and concise regulations and enforcement against fraudulent, deceptive or misleading advertising as well as transparency and disclosure of one’s degree, board certification and licensure. America’s patients deserve to know what procedures their providers are qualified and licensed to perform. The AADA believes those who regulate and deliver medical care have an obligation to inform the public of the qualifications and limitations of their care prior to beginning treatment, and should identify or disclose their degree or field of study, board-certification (if any) and licensure to each patient. This should be disclosed verbally or displayed prominently in writing.

The AADA is supportive of federal and state policies which seek the following:

- Increased transparency in licensure and board certification, including:
  - Required disclosures that a physician is certified, or eligible for certification by a private or public board, parent association, or multidisciplinary board or association that is an American Board of Medical Specialties member board, a board or association with equivalent requirements approved by that physician's licensing board, or a board or association with an Accreditation Council for Graduate Medical Education approved postgraduate training program that provides complete training in their specialty or subspecialty in all identification and advertisements;
  - Required disclosure of one's degree or field of study and licensure, including the use of clarifying titles (e.g. Dr. Jane Doe, Doctor of Nursing Practice; Dr. John Doe, Doctor of Naturopathy; Jane Doe, Physician Assistant);
  - Use or display of visible identification, including credentials, for all levels of personnel in private medical practices, hospitals, clinics or other settings employing physicians or other personnel which offer medical, surgical or aesthetic procedures.
  - Any other means which protects the public against fraudulent, deceptive or misleading advertising.

- Creation of public education campaigns regarding qualifications of medical professionals.

Approved by the Board of Directors 8/7/10
2012 Ethics Committee

Jack S. Resneck, Sr., MD, Chair 2013
Lionel Bercovitch, MD 2015
Alfred Knable, MD 2013
Alfred Lane, MD 2015
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