



Historic Changes in the AMA's Code of Ethics



By Ed Rudin, MD

The House of Delegates has adopted two new principles: the physician's duty to the patient comes first; and physicians have a responsibility to serve all, regardless of means.

WHEN THE HOUSE OF DELEGATES of the AMA, at its Interim Meeting in December 2000, approved several minor language revisions, that did not seem newsworthy.

When the same group met in mid-June 2001 and adopted the proposal of the Council on Ethical and Judicial Affairs to add two principles to the long-established seven, that was newsworthy. Indeed it was historic.

Why More Principles?

Have the marked changes in medical care delivery had such an impact on physicians' relationships with patients, colleagues, systems of care, and society to demand these additional principles?

The Council started examining the impact of new medical care systems on physicians' relationships with patients, colleagues, systems of care, and society in 1997. It collected codes of ethics from state and specialty societies nationwide and from organizations throughout the world, and held several forums to gather opinions and suggestions. Among the reports considered was the 1997 Consensus Statement of the Council of Medical Specialty Societies, a product of two years of work by diverse specialists.

On physician-patient relationships, the consensus upheld the physician's "primary inviolate role ... as an active advocate for each patient's care and well-being" and the physician's obligation to "treat each patient with honesty, compassion, dignity, and respect for individual autonomy." To this traditional view, the CMSS added an obligation to provide health education and continuity of care.

It shifted the "responsibility to maintain moral integrity, intellectual honesty, and clinical competence" and the traditional "obligation to educate and share information with colleagues, including physicians in training" from a physician-society responsibility to a physician-physician responsibility.

Responsibility to the Patient

CCMS broke new ground - most boldly - on relationships with systems of care, stating unequivocally the primacy of the physician's responsibility to the patient above all other responsibilities:

- "Patient advocacy should not be altered by the system of health care delivery in which the physician practices."
- "Resolve conflicts of interest in a way that gives primacy to the patient's interests."
- "Provide knowledgeable input into organizational decisions on the allocation of

medical resources and the process of health care delivery."

That is one of the principles now added to the Code of Medical Ethics: the duty to the patient comes first.

Furthermore, the consensus on physician-society relationships shattered the long silence of our Code of Ethics on universal health care. Physicians, it said, have an ethical obligation to "serve the health care needs of all members of society," to "participate in the formation of health care policy," and to "preserve and protect the trust bestowed on them by society."

The noted medical ethicist, Edmund Pellegrino, in supporting the consensus, warned that even today's tense, conflicting obligations to individual patients and to society do not change the physician's primary obligation to the patient; the physician must not function as a double agent.¹ Brody² considered this patient-centered ideal a "comforting myth" in today's complex challenges to medical professionalism, and Hall and Berenson³ offered a compromise, encouraging physicians to do the best they can within what their practice group or insurance plan allows.

Other physician-ethicists had already lowered the bar. They had exempted physicians working in the justice and corrections system, the military and the insurance industry from a primary obligation to the patient. They propose instead that those physicians have a primary obligation to the social goals of their institution.^{4,5}

They need only disclose their conflicts of interest to their patients, empathetically informing them of the impact on their medical care and of the options for their resolution. They should also advocate for the patient in seeking to revise restrictive or harm-risking policies. But their obligation to the institution could be primary.

Kluft warned that physicians must guard against "abusing" patients by allowing them to receive suboptimal treatment. Subsequent court cases have proved the warning was justified.

Responsibility to Serve All

The second addition to the Code of Ethics requires physicians to support universal access to health care. At the winter meeting in Florida, several AMA delegates worried that this might be misinterpreted as a call for socialized medicine or support for a single-payer system.

The Texas delegation tried to stall an interim vote. In response, the vice-chair of CEJA explained that the Council was not advocating a particular delivery system, it was merely stating an ethical physician obligation to seek medical care for all sick people, regardless of means. The discussion and the vote upheld this position.

The AMA's Code of Ethics had been one of the few modern medical codes without such a declaration of principle. It appears in some of the earliest codes of medical ethics, from the Chinese Canon of Medicine (circa 200 BCE to 200 CE) to Avicenna and Maimonides (circa 1100-1200 CE). But it was not deemed relevant to the 1789 problems that led to Percival's Medical Ethics (1803), the precursor of the AMA code. The AMA has resisted since then - until now.

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