

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS[□]

CEJA Report 1-A-01

Subject: The Patient-Physician Relationship

Presented by: Herbert Rakatansky, MD, Chair

Presented to: Reference Committee on Amendments to Constitution and Bylaws
(William J. Mangold, Jr., MD, Chair)

1 Introduction

2
3 At the center of the history of the American Medical Association lies its *Code of Medical Ethics*.
4 The original *Code* of 1847 promulgated an ethic that emphasized conduct rather than character. It
5 was premised on the understanding that the very nature of the physician's responsibility consisted
6 of caring for the sick and that this was a responsibility owed by all physicians to all patients.¹
7 Also, building upon the Hippocratic tradition, physicians were called upon to hold a sense of
8 ethical obligation that rose above considerations of personal advancement.² According to one
9 commentator, "the central moral commitment of the code was its dedication to something other
10 than the physician's self-interest, that something being the primacy of the welfare of the patient."³

11
12 The current *Code's* focus on the relationship between physician and patient is exemplified by the
13 *Fundamental Elements of the Patient-Physician Relationship* issued in 1990.⁴ In particular,
14 physicians are to foster this partnership by providing information and allowing for autonomous
15 decision-making, acting respectfully and in a timely manner, preserving confidentiality, ensuring
16 continuity of care, and facilitating access to care. Despite this list of features of the relationship
17 patients can expect from physicians and which physicians must strive to fulfill, the very nature of
18 the patient-physician relationship remains unexamined.

19
20 The patient-physician relationship, which is at the heart of the AMA's *Code of Medical Ethics*, is
21 the focus of this report.

22 23 Conceptualizing the patient-physician relationship

24
25 According to one medical ethicist, there is no single characterization that can properly do justice
26 to the patient-physician relationship "given the complexity of professional styles, patient
27 expectations and values, and contexts in which the relationship is established."⁵ For example,
28 patients treated for chronic diseases may have long-established relationships with their
29 physicians, or may be interacting with a specialist for a single consult.

30
31 Irrespective of the circumstances of the encounter between patient and physician, medical
32 ethicists have characterized it in terms of a moral activity. This has been found to arise from the
33 condition that brings patients into contact with physicians, namely illness. "Healing is sought for
34 concerns that go to the root of human existence: fears of death, deformity, and disability."⁶
35 Patients have been described in terms of their vulnerability, and consequently exploitable state,

[□] Reports of the Council on Ethical and Judicial Affairs are assigned to the Reference Committee on Constitution and Bylaws. They may be adopted, not adopted, or referred. A report may not be amended, except to clarify the meaning of the report and only with the concurrence of the Council.

1 and their dependence on the medical expertise and the compassion of physicians. In order to
2 maintain good health or to secure the treatments that will alleviate their ills, patients, or surrogate
3 decision-makers on their behalf, agree to enter into relationships with physicians. At times, the
4 agreement to enter into a relationship is implied, such as when a patient is unconscious and in
5 need of emergency care, or when physicians provide a specific service at the request of the
6 treating physician (e.g. the services of a pathologist). Physicians also agree to enter the
7 relationship; either directly, as agents, or by previous contractual arrangements to treat a group of
8 patients. The relationship, therefore, is established by mutual agreement. In some rare instances,
9 such as legally mandated treatment as described in Opinion 2.065, “Court-Initiated Treatments in
10 Criminal Cases,”⁷ treatment may be provided by a physician even though a patient has not
11 consented to entering into a relationship. In such circumstances, physicians remain bound by the
12 same obligations.

13
14 Once the relationship has been established, patients should be confident that they are receiving
15 the best medical care their physicians can provide, uncompromised by external factors. However,
16 the medical profession currently finds itself amidst tensions between physicians’ altruistic
17 covenant to provide needed medical care to patients and the market ethos of profit-making.⁸

18 19 Ethical obligations of physicians

20
21 Trust is central to the patient-physician relationship. Physicians provide specialized knowledge
22 and expert skills that are relied upon by patients. Physicians also hold considerable control over
23 medical resources used for the benefit of patients.

24
25 Many ethicists have emphasized the obligation of fidelity that is owed whenever the physician
26 establishes a relationship with the patient.⁹ One important manifestation of this obligation of
27 fidelity is the ethical obligation not to abandon a patient, which would undermine physicians’
28 trustworthiness. CEJA Opinion 8.115, “Termination of the Physician-Patient Relationship”
29 embodies this obligation to ensure continuity of care. Viewed from a different perspective,
30 medicine is an act of “profession” whereby physicians promise to use their knowledge to help and
31 to heal.¹⁰

32
33 The patient-physician relationship is held to high standards of conduct, as embodied in the *Code*
34 *of Medical Ethics*. This characterization of the patient-physician relationship differs significantly
35 from the contractual view of the relationship in which patients seek care and physicians provide
36 it.¹¹ Ethically, it would be insufficient to view health care as an ordinary service and to allow
37 care that patients request from physicians to be governed by the maxim “let the buyer beware.”

38
39 However, much of the current health care delivery system operates according to the dynamics of
40 the market. According to many participants in this system, profit-making is a legitimate goal and
41 financial incentives are important tools in controlling health care resources. This reality confers
42 even greater importance onto the principal feature of the patient-physician relationship, which
43 require that patients’ interests be given priority. Therefore, external factors that may result in
44 compromising medical judgment deserve careful examination.

45 46 Conflicts of interest

47
48 Many ethicists have long argued that some effacement of self-interest is morally obligatory for
49 physicians.⁸ This notion is captured throughout the *Code of Medical Ethics*.

1 *Conflicts between physicians' and patients' interests*

2
3 Physicians' self-interest that may conflict with the interests of patients is addressed in
4 unambiguous terms in Opinion 8.03, "Conflicts of Interest: Guidelines," which states that "Under
5 no circumstances may physicians place their own financial interests above the welfare of their
6 patients (...) If a conflict develops between the physician's financial interest and the physician's
7 responsibilities to the patient, the conflict must be resolved to the patient's benefit."
8

9 More troubling in this era of managed care are some of the methods used to accomplish cost
10 containment. Specifically, various risk-bearing arrangements that affect physicians' incomes
11 according to their use of health care resources may lead to limitations that could be harmful to
12 patients. In Opinion 8.054, "Financial Incentives and the Practice of Medicine," physicians are
13 advised to evaluate financial incentives included in managed care contracts to ensure that quality
14 of patient care is not compromised by placing physicians' payments at excessive risk or by setting
15 unrealistic expectations for utilization. The Opinion also recommends that large financial
16 incentives should be limited in order to prevent physicians' personal financial concerns from
17 creating a conflict with their role as individual patient advocates.
18

19 *Conflicts between individual patients and patient populations*

20
21 Managed care's use of financial incentives to influence physicians' decision-making also has led
22 to a shift from patient-focused medicine to population-based medicine. In order to stay within
23 budgetary limits, physicians are urged, often through financial and other incentives, to consider
24 the impact of the decisions they make on an entire group of patients, rather than on a single
25 patient. Physicians who allow such incentives to color medical judgement become primarily
26 agents of the health plan rather than of individual patients.¹² It would seem more likely that
27 patients' trust in physicians will be best preserved if those who are ill can expect their physicians
28 to be advocates for optimal care and not just some minimal standard.¹² However, systemic
29 budgetary constraints may in fact prevent patients from obtaining access to the optimal level of
30 care necessary to treat a condition. Faced with such prospects, patients must find allies who will
31 assist them in gaining access to the resources needed to treat their condition. In an earlier
32 report,¹³ the Council clearly identified that physicians have a duty of patient advocacy that should
33 not be altered by the system of health care delivery, and that requires physicians to advocate for
34 any care they believe will materially benefit their patients.
35

36 Conclusion

37
38 The medical profession must strive to preserve the trust patients hold in their physicians. It
39 cannot abandon ethical standards to economic forces. As individual physicians advocate for the
40 care their individual patients require, so must the medical profession advocate for access to care
41 for all. Individual physicians must work to forge strong alliances with their own patients, and the
42 medical profession with the public, to preserve the integrity of the profession.
43

44 Recommendations

45
46 The Council recommends that the following be adopted and the remainder of the report be filed:
47

48 The practice of medicine, and its embodiment in the clinical encounter between a
49 patient and a physician, is fundamentally a moral activity that arises from the
50 imperative to care for patients and to alleviate suffering. The relationship
51 between patient and physician is based on trust and gives rise to physicians'

1 ethical obligations to place patients' welfare above their own self-interest and
2 above obligations to other groups, and to advocate for their patients' welfare.

3
4 A patient-physician relationship is generally created by mutual agreement
5 between physician and patient (or surrogate). In some instances the agreement is
6 implied, such as in emergency care or when physicians provide services at the
7 request of the treating physician. In rare instances, treatment without consent
8 may be provided under court order (see Opinion 2.065). Nevertheless, the
9 physician's obligations to the patient remain intact.

10
11 Within the patient-physician relationship, a physician is ethically required to use
12 sound medical judgment, holding the best interests of the patient as paramount.

REFERENCES

- ¹ Baker RB. The American Medical Ethics Revolution. In: *The American Medical Ethics Revolution*. Baker RB, Caplan AL, Emanuel LL, Latham SR, eds. Baltimore, Md: Johns Hopkins University Press; 1999: 17-51.
- ² Bell J. Introduction to the 1847 Code of Ethics (Appendix B) In: *The American Medical Ethics Revolution*. Baker RB, Caplan AL, Emanuel LL, Latham SR, eds. Baltimore, Md: Johns Hopkins University Press; 1999:317-323.
- ³ Pellegrino ED. Moral status and relevance of the code. In: *The American Medical Ethics Revolution*. Baker RB, Caplan AL, Emanuel LL, Latham SR, eds. Baltimore, Md: Johns Hopkins University Press; 1999:107-123.
- ⁴ Council on Ethical and Judicial Affairs, Opinion 10.01, Fundamental Elements of the Patient-Physician. In *Code of Medical Ethics: Current Opinions, 2000-2001*. AMA Press, Chicago, IL, 2000.
- ⁵ Thomasma, DC. Beyond medical paternalism and patient autonomy: a model of physician conscience for the physician-patient relationship. *Ann Intern Med*. 1983; 98: 243-248.
- ⁶ Engelhardt HT Jr. *The Foundations of Bioethics*. 2nd ed. New York, NY: Oxford University Press; 1996.
- ⁷ Council on Ethical and Judicial Affairs, Opinion 2.065, Court-Initiated Medical Treatments in Criminal Cases. In *Code of Medical Ethics: Current Opinions, 2000-2001*. AMA Press, Chicago, IL, 2000
- ⁸ Pellegrino ED, Thomasma DC. *The Virtues in Medical Practice*. New York, NY; Oxford University Press:1993.
- ⁹ Beauchamp TL, Childress JF. *Principles of Biomedical Ethics*. 4th ed. New York, NY; Oxford University Press; 1994.
- ¹⁰ Pellegrino ED. Toward a virtue-based normative ethics. *Kennedy Institute of Ethics J*. 1995;5:253-277.
- ¹¹ Howard ML, Vogt LB. Physician-patient relationship. In *Legal Medicine*. 3rd ed. American College of Legal Medicine. (Mosby; Saint-Louis, Missouri, 1995).
- ¹² Kassirer JP. Managing care-Should we adopt a new ethic? *New Engl J Med*. 1998;339:XX.
- ¹³ Council on Ethical and Judicial Affairs. Ethical Issues in Managed Care. *JAMA*. 1995;273:330-335.