

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 4-A-00

Subject: Potential Patients: Ethical Considerations

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1
2 Introduction
3

4 Physicians are professionals and as such have obligations to use their skill and knowledge for the
5 benefit of society. Although physicians retain a great degree of control over their practice, they
6 often must subjugate their self-interest to the interests of patients. As service professionals,
7 physicians may not always have the prerogative of choosing whom to serve. Professional
8 responsibilities to provide care, the need for patients to receive care, and the responsibility to act
9 in the best interest of patients, all place limits on physicians' prerogative to select their patients.

10
11 The Council offers the following report to identify limits on physicians' choice of patients and the
12 circumstances in which physicians may be obligated to provide medical care. This report
13 addresses only those situations in which there is no pre-existing patient-physician relationship, so
14 the focus is on a physician's choice regarding whether to accept an individual as a patient. The
15 report begins by examining the concept of physician choice of patients and outlines criteria
16 according to which, and situations in which, it would be unethical for the physician to decline to
17 treat a potential patient. It then identifies situations in which a physician may decline to treat.
18 Finally, it attempts to provide guidance regarding the extent and limits of a positive obligation to
19 treat in less clear cases.
20

21 Choice in the Patient-Physician Relationship
22

23 The Council recognizes that *a priori* both patients and physicians should be able to exercise
24 freedom in choosing with whom to enter into a patient-physician relationship. In Opinion 9.06,
25 "Free Choice," the Council definitively states that patients should have a choice when selecting a
26 physician: "[f]ree choice of physicians is the right of every individual. One may select and
27 change at will one's physicians" ¹ The Council acknowledges, however, that limits exist on
28 the patient's ability to choose physicians. For example, the Opinion states that "emergency
29 treatment in cases of accident or sudden illness may, as a practical matter, preclude free choice in
30 physician." ²
31

32 Correspondingly, physicians can exercise their prerogative to select whom to treat by assenting to
33 or declining to enter into a patient-physician relationship. Opinion 9.06, "Free Choice," states
34 that "[a]lthough the concept of free choice assures that an individual can generally choose a
35 physician, likewise a physician may decline to accept that individual as a patient." ³ But this

¹ 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 privilege is not absolute and there are circumstances in which a physician may have an obligation
2 to undertake treatment.

3
4 There are two bases for physicians' prerogative to choose whom to treat. The first is a general
5 privilege held by all members of society that accords individuals a right to choose with whom to
6 associate. Physicians do not give up their freedom of association merely by becoming
7 professionals. But they do assume certain obligations that place limits on their choices in the
8 context of serving patients. The second aspect of the physicians' prerogative stems from the
9 notion of professionalism. Physicians are granted enormous autonomy within the context of the
10 patient-physician relationship and this autonomy includes the freedom to choose whether to
11 undertake the treatment of a particular patient. However, this autonomy is not designed to further
12 physicians' self-interests. Rather it is a necessary element of assuring patients the best possible
13 care. Since medical professionals are trained in a complex body of knowledge, and non-
14 professionals are not able to judge how that knowledge should be applied in particular cases,
15 physicians are often accorded the freedom to make medical decisions on their own—or
16 autonomously. The purpose of the exercise of autonomy in this context is not the furtherance of
17 the physician's interests, but those of the patient.

18
19 On what grounds can the prerogative to choose be curtailed? First, it may be limited by factors
20 such as legal requirements not to discriminate, or requirements for emergency care. Second, the
21 autonomy generally granted to the physician should be limited to the extent that it may only be
22 exercised in patients' interests and, therefore, there are cases where a physician should decline to
23 take on the care of a patient. When the prerogative to choose whom to treat and the obligations to
24 treat are less clearly delineated, physicians will have to weigh a number of factors in deciding
25 whether to take on the care of a patient. Each of these examples is explained in more detail below.

26 27 Obligation to Treat

28
29 Although a physician's ability to select patients is acknowledged by the "Principles of Medical
30 Ethics," several existing Opinions in the *Code of Medical Ethics* place limits on the prerogative to
31 select whom to treat. The situations described below are instances in which it would be clearly
32 unethical and perhaps illegal to refuse a patient since physicians' professional responsibility to
33 provide care would override their privilege to choose.

34 35 A. Emergency Situations

36
37 Physicians' responsibility to treat patients in emergency situations is referred to in Opinion 8.11,
38 "Neglect of Patient." The opinion states that a "physician should...respond to the best of his or
39 her ability in cases of emergency where first aid treatment is essential."⁴ At a minimum,
40 physicians ought to help stabilize an individual in these situations.

41
42 It may be difficult to determine what constitutes an emergency situation. An emergency can be
43 defined as "[a]n unexpected development or happening; a sudden need for action."⁵ However, a
44 continuum exists in medical care with some cases clearly emergent and others less so. In
45 situations where the physician has doubt about the emergent nature of the case, he or she should
46 attempt to act in the patient's best interest. Emergency situations in which a physician is asked to
47 provide care beyond his or her competence must be evaluated on a case-by-case basis.

48 49 B. Patient Characteristics

50

1 In Opinion 9.12, “Patient-Physician Relationship: Respect for Law and Human Rights,” the
2 Council states that “[p]hysicians who offer their services to the public may not decline to accept
3 patients because of race, color, religion, national origin, sexual orientation, or any other basis that
4 would constitute invidious discrimination.”⁶ The general obligation to provide care should not be
5 contingent on the characteristics of individuals. Selecting whom to treat based on such criteria
6 would be unprofessional and possibly illegal.

7
8 C. Infectious Diseases
9

10 Similarly, Opinion 2.23, “HIV Testing,” prohibits physicians from discriminating against patients
11 who are, or may be, HIV positive. The Council states that “[i]t is unethical to deny treatment to
12 HIV-infected individuals because they are HIV seropositive or because they are unwilling to
13 undergo HIV testing, except in the instance where knowledge of the patient’s HIV status is vital
14 to the appropriate treatment of the patient.”⁷ In the report, “Ethical Issues Involved in the
15 Growing AIDS Crisis,” the Council reasoned that the “tradition of the American Medical
16 Association, since its organization in 1847, is that ‘when an epidemic prevails, a physician must
17 continue his labors without regard to the risk to his own health.’”⁸ By agreeing to enter the
18 profession, physicians consent to face some level of risk inherent to the profession and training
19 they received.⁹

20
21 D. Preexisting contractual arrangement
22

23 A physician has an obligation to treat a potential patient if the physician is operating under a
24 contractual arrangement that requires the physician to provide treatment. Such contractual
25 arrangements are created, in part, to ensure that all patients in a certain context receive the care
26 they require. For instance, once a physician has agreed to serve as an on-call physician, he or she
27 has agreed to see all patients that require care during a limited time period. For the benefit of
28 patients, the on-call physician temporarily forfeits his or her privilege in deciding whom to serve.
29 Accordingly, Opinion 9.12, “Patient-Physician Relationship: Respect for Law and Human
30 Rights,” states that “[p]hysicians who are obligated under preexisting contractual arrangements
31 may not decline to accept patients as provided by those arrangements.”¹⁰

32
33 However, exceptions to this may exist, especially if patient care is ultimately compromised by the
34 contractual arrangement. For instance, the Council discourages physicians from entering
35 managed care plans in which incentives set unrealistic expectations for utilization or place the
36 physician at excessive financial risk and threaten to compromise the quality of patient care.¹¹
37 Furthermore, contractual arrangements that create a barrier to providing adequate patient care
38 should be avoided.¹²

39
40 Justifiable Refusal to Treat
41

42 The above situations describe instances when physicians cannot ethically refuse to provide care.
43 There are also circumstances in which physicians may decline to treat a patient. In these cases,
44 the physician must use his or her discretion in determining whether to undertake an individual’s
45 care.

46
47 A. Treatment requests beyond physician’s current competence
48

49 Opinion 9.12, “Patient-Physician Relationship: Respect for Law and Human Rights,” recognizes
50 that patients might approach physicians with treatment requests that clearly are beyond the
51 physician’s training or ability. It states: “[a] physician may decline to undertake the care of a

1 patient whose medical condition is not within the physician’s current competence.”¹³ In such
2 situations, the physician is expected to inform the patient about his or her inexperience with a
3 particular problem and suggest that he or she seek care from another physician. Such refusals are
4 focused on protecting the patient’s best interests.

5
6 B. Invalid treatment requests
7

8 In the era of modern medicine, options for promoting health and treating illness abound. At the
9 same time, patients are becoming more informed about their ailments and are playing a larger role
10 in suggesting a course of treatment.¹⁴ As a result, patients are more likely than ever to have
11 strong opinions about various treatments or to make treatment requests with which some
12 physicians may not agree.

13
14 When potential patients approach a physician with a specific treatment request that is known to
15 be harmful, physicians have an ethical responsibility to decline to treat the individual (Opinion
16 3.01: “Nonscientific Practitioners”). Furthermore, Opinion 8.20, “Invalid Medical Treatment,”
17 specifically states that “[t]reatments which have no medical indication and offer no possible
18 benefit to the patient should not be used.”¹⁵ Physicians should explain how the treatment request
19 could be harmful or how it offers no benefit to patients referring to clinical outcome measures
20 when appropriate. If the potential patient remains steadfast in his or her request for treatments
21 that do not meet the standard of care and could prove harmful, the physician is justified in
22 declining to provide the specified care. However, patients should not be forced to accept a
23 specific treatment as a precondition to seeing a physician.

24
25 C. Treatment Requests that Conflict with the Physician’s Religious, Moral, or Personal
26 Beliefs
27

28 Occasionally, a physician might be faced with a treatment request that is accepted widely by the
29 medical community but incompatible with his or her religious, moral, or personal beliefs.
30 Physicians should not be required to violate or revoke strongly held beliefs by virtue of entering
31 the medical profession. In these exceptional situations, a physician may be justified in declining
32 to undertake the care of a patient.¹⁶ The physician should provide an explanation as to why he or
33 she chooses not to treat the patient. Physicians who hold beliefs that might preclude potential
34 patients from receiving necessary care should be able to anticipate such situations and might
35 consider possible alternatives for individuals in need of care. A physician could inform his or her
36 colleagues about beliefs that would interfere with patient care, and make arrangements in advance
37 to help the individual find another physician. For instance, physicians whose beliefs preclude
38 them from performing abortions but who are likely to see women requesting such a procedure
39 might have a referral mechanism in place. Another option may be to work provisions into an
40 employment contract that would allow other physicians to deliver needed care when a physician
41 is confronted with a treatment that conflicts with his or her religious, moral, or personal beliefs.
42 By addressing these types of scenarios in advance, physicians would have options available to
43 them when asked to perform procedures or provide treatments that are incompatible with their
44 personal beliefs.

45
46 If physicians wish to discuss a treatment with which they disagree, they should do so based on
47 sound medical evidence and not on their personal beliefs. For example, Opinion 2.12, “Genetic
48 Counseling,” states that when discussing genetic testing with prospective parents, “physicians
49 should avoid the imposition of their personal moral values and the substitution of their own moral
50 judgment.”¹⁷ Relying heavily on personal, moral, or religious beliefs when attempting to
51 dissuade patients from pursuing a treatment could ultimately erode patients’ faith in physicians’

1 ability to provide them with objective medical advice. When declining to treat a patient on these
2 grounds, the physician should be careful that the reasons for refusal are not directed at the
3 potential patient, or characteristics of the individual, but rather at the treatment requested by the
4 individual.

5
6 General considerations in other cases

7
8 There are a number of other situations in which the physician’s obligation to take on the treatment
9 of a potential patient is less clear. For example, a physician may be the only specialist or health
10 care provider available in a particular area. In general, physicians do have some special
11 obligations to provide service that is embodied in the meaning of professionalism.

12
13 A contentious issue in respect to physicians’ obligations to treat often arises in the context of a
14 patient who is unable to pay for treatment. Currently, there is no societal or professional
15 consensus regarding individual physicians’ obligations to treat beyond those outlined for
16 emergency care. But the *Code* does provide some guidance regarding positive obligations with
17 respect to care of indigent patients. In Opinion 9.065, “Caring for the Poor,” the Council states
18 that: “Each physician has an obligation to share in providing care to the indigent.... Caring for the
19 poor should be a regular part of the physician’s practice schedule.”¹⁸ But this obligation is not
20 unlimited.¹⁹ For example physicians are not required to jeopardize the overall financial stability
21 of their practice or the health of other patients.* However, a reasonable effacement of self-interest
22 is a hallmark of any profession. The extent to which a physician fulfills his or her obligations in
23 this context is matter of individual character and circumstance, but its complete absence is a lapse
24 for any professional.²⁰

25
26 In general, physicians should consider the following in deciding whether to take on a new patient.
27 First, physicians should consider the level of the patient’s need for a service. For example, is the
28 service necessary to sustain life (e.g., dialysis), necessary to sustain functioning health (e.g.,
29 resetting a bone), useful to sustain functioning health (e.g., allergy treatments), or discretionary
30 (e.g., laser removal of a benign but unsightly mark)? These examples are only a few along a vast
31 continuum of health care services. Physicians’ obligations to treat are clearly stronger the greater
32 the patient need. Second, the needs of the physician’s current patients should be taken into
33 account. Physicians may refuse to take new patients if doing so would compromise the care of
34 existing patients.²¹ Thus, a physician with a full practice in a rural area could refuse additional
35 patients if treating them would compromise the fundamental care his or her other patients
36 received. However, if the physician is able to anticipate such situations and address the problem
37 in advance, he or she is less likely to have to pit the interests of existing patients against the needs
38 of prospective patients.

39
40 Conclusion

41
42 The need for patients to receive care, coupled with physicians’ responsibility to act in the best
43 interest of patients and the public, places limits on physicians’ prerogative to select their patients.
44 Therefore, physicians exercising their prerogative to choose whether to enter into a patient-
45 physician relationship must take their professional obligations to serve patients into consideration.

46
47

* The Council recognizes that some patients may pose a physical threat not only to other patients but also to treating physicians. The issue of personal risk in treating a potentially violent patient deserves a more in depth analysis than permitted by this report.

1 Recommendations

2
3 For the foregoing reasons, the Council recommends the following be adopted and that the remainder of
4 this report be filed:

- 5
6 (1) Physicians must keep their professional obligations to provide care to patients in accord
7 with their prerogative to choose whether to enter into a patient-physician relationship.
8
9 (2) The following instances identify the limits on physicians' prerogative:
10
11 (a) Physicians should respond to the best of their ability in cases of medical
12 emergency (Opinion 8.11, "Neglect of Patient").
13
14 (b) Physicians cannot refuse to care for patients based on race, gender, sexual
15 orientation, or any other criteria that would constitute invidious discrimination
16 (Opinion 9.12, "Patient-Physician Relationship: Respect for Law and Human
17 Rights"), nor can they discriminate against patients with infectious diseases
18 (Opinion 2.23, "HIV Testing").
19
20 (c) Physicians may not refuse to care for patients when operating under a contractual
21 arrangement that requires them to treat. (Opinion 9.12, "Patient-Physician
22 Relationship: Respect for Law and Human Rights"). Exceptions to this
23 requirement may exist when patient care is ultimately compromised by the
24 contractual arrangement.
25
26 (3) In situations not covered above, it may be ethically permissible for physicians to decline
27 a potential patient when:
28
29 (a) the treatment request is beyond the physician's current competence (Opinion
30 9.12, "Patient-Physician Relationship: Respect for Law and Human Rights").
31
32 (b) the treatment request is known to be scientifically invalid, has no medical
33 indication, and offers no possible benefit to the patient (Opinion 8.20, "Invalid
34 Medical Treatment").
35
36 (c) a specific treatment sought by an individual is incompatible with the physician's
37 personal, religious, or moral beliefs.
38
39 (4) Physicians, as professionals and members of society, should work to assure access to
40 adequate health care (Fundamental Element VI).^{*} Accordingly, physicians have an
41 obligation to share in providing charity care (Opinion 9.065, "Caring for the Poor") but
42 not to the degree that would seriously compromise the care provided to existing patients.
43 When deciding whether to take on a new patient, physicians should consider the
44 individual's need for medical service along with the needs of their current patients.
45 Treatments range along a continuum from necessary to sustain life, to necessary to
46 sustain functioning health, to useful to sustain functioning health, to discretionary.
47 Clearly, greater individual need for a service corresponds with a stronger obligation to
48 treat.

* Considerations in determining an adequate level of health care are outlined in Opinion 2.095: "The Provision of Adequate Health Care." Council on Ethical and Judicial Affairs, American Medical Association. *Code of Medical Ethics* 1998; Chicago, IL.

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- ¹⁵ Council on Ethical and Judicial Affairs, American Medical Association. “Opinion 8.20: Invalid Medical Treatment.” *Code of Medical Ethics: Current Opinions with Annotations*. Chicago, IL: American Medical Association, 1998.
- ¹⁶ House of Delegate Policy 5.995, “Abortion,” states: “Neither physician, hospital, nor hospital personnel shall be required to perform any act violative of personally held moral principles.” Issued Jun 1977, most recently reaffirmed June 1997.
- ¹⁷ Council on Ethical and Judicial Affairs, American Medical Association. “Opinion 2.12: Genetic Counseling.” *Code of Medical Ethics: Current Opinions and Annotations*. Chicago, IL, 1998.
- ¹⁸ Council on Ethical and Judicial Affairs, American Medical Association. “Opinion 9.065: Caring for the Poor.” *Code of Medical Ethics: Current opinions and annotations*. Chicago, IL, 1998.
- ¹⁹ All of this is not to imply that individual charity care relieves society of its general responsibility to ensure adequate health care for all members. Until society has established a universal system of health care coverage, physicians have a general responsibility to advocate for access to adequate health care. Council on Ethical and Judicial Affairs, American Medical Association. “Opinion 2.095: The Provision of Adequate Health Care.” *Code of Medical Ethics: Current Opinions and Annotations*. Chicago, IL, 1998.
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