

Highlights of the Code of Medical Ethics of the American Medical Association

Section E-10.00, “Opinions on the Patient-Physician Relationship”

Section 10, “Opinions on the Patient-Physician Relationship” is the most recent section in the *Code of Medical Ethics*. However, even prior to its introduction in the 2000-2001 edition, many of the professional responsibilities it defines already were addressed elsewhere in the *Code*, whether in the Principles of Medical Ethics or in other sections. Indeed, with its focus on the patient-physician relationship, the section speaks to notions that are central to medical ethics and professionalism. In particular, it considers the rights and responsibilities of each of the two parties in the dyad. Opinions in Section 10 also attempt to define what constitutes a patient-physician relationship—first in a general context, then in terms of whether the relationship exists under specific circumstances. Finally, the last section of the *Code* offers some parameters on physician choice regarding whether to accept an individual patient.

It is noteworthy that the principle of reciprocity, on which current Opinions 10.01, “Fundamental Elements of the Patient-Physician Relationship” and 10.02, “Patient Responsibilities” are based, appeared in the original 1847 *Code of Medical Ethics*. The idea that for every right there is a corresponding obligation was transformative for American medicine. Indeed, American medical ethics and professionalism became fashioned on the model of a social contract, as described

in the original *Code’s* Chapter I, “Of the Duties of Physicians to Their Patients, and of the Obligations of Patients to Their Physicians.” “The members of the medical profession, upon whom are enjoined the performance of so many important and arduous duties toward the community, and who are required to make so many sacrifices of comfort, ease, and health, for the welfare of those who avail themselves of their services, certainly have a right to expect and require, that their patients should entertain a just sense of the duties they owe to their medical attendants.” In return, for placing some responsibilities upon patient, this contractarian structure did grant members of society the implicit right to make demands of individual physicians and the medical profession as a whole.¹

Opinion 10.01 identifies the relevance of a partnership between patient and physician to the health and well-being of the patient. Though it outlines some basic responsibilities of the patient, the opinion primarily provides an overview of the fundamental elements to which patients are entitled in the context of the patient-physician relationship. These are specified both in terms of physicians’ essential duties to their patients—“physicians should”—and of patients’ expectations—“patients have a right to. . .” This policy comprises major ethical considerations, including informed consent, confidentiality and access to records, access to care, and continuity of care—all of which are developed in more detail elsewhere in the *Code*.

Opinion 10.02 complements 10.01 by

considering what responsibilities accompany the rights that patients may enjoy in medicine: “While physicians have the responsibility to provide health care services to patients to the best of their ability, patients have the responsibility to communicate openly, to participate in decisions about the diagnostic and treatment recommendations, and to comply with the agreed upon treatment program.”

More specifically, the policy identifies duties, which include providing a complete medical history, discussing end of life decisions, as well as organ donation, and reporting illegal or unethical behavior by physicians.

The inclusion of patient responsibilities in the *Code* sometimes has been described as inappropriate. Indeed, some contend this policy puts the burden on patients to perform activities that fall more directly under a physician’s professional duties. In addition, the profession ought not to set norms for the layperson. However, as noted already, these very responsibilities and the social contract nature of the *Code* also grant patients the right to make demands on the profession.

Beyond trying to identify the rights and obligations of each party in the patient-physician relationship, the *Code* more recently has attempted to define the characteristics that establish a patient-physician relationship, from which guidelines under this section flow. “A patient-physician relationship exists when a physician serves a patient’s medical needs, generally by mutual consent between physician and patient.” Opinion 10.015, “The Patient-Physician Relationship,” from which this definition is taken, was issued in December 2001, providing a useful description that previously had been absent in the *Code*. Until then, the *Code* had approached this question only from a very specific angle—namely, whether

a patient-physician relationship existed in limited circumstances of work-related or independent medical examinations. Opinion 10.03, "Patient-Physician Relationship in the Context of Work-Related and Independent Medical Examinations," had confirmed the existence of a limited relationship, on the basis that physicians in these contexts shared many of the same responsibilities as physicians in the ordinary clinical setting.

Having considered the responsibilities of physicians and patients, as well as the nature of the patient-physician relationship, this section ends with Opinion 10.05, "Potential Patients." Essentially, this policy acknowledges that the rights that patients and physicians enjoy are not absolute. Specifically, it sets parameters on physicians' discretion in establishing a therapeutic relationship with a patient. The Opinion considers how physicians' freedom to

choose whom to treat, as enunciated in Principle VI, is tempered by Principle IX, recognizing physicians' responsibility to support access to medical care for all. Physicians are required to treat in medical emergencies. Furthermore, physicians should not decline to treat patients for reasons related to invidious discrimination or in violation of contractual agreement. They may, however, decline a potential patient in circumstances where they lack competence to provide necessary care, where care would be medically unnecessary, or where a specific treatment sought by a patient is inconsistent with the physician's personal values. Finally, physicians should be mindful, in their decisions, of their collective responsibility to work to assure access to adequate health care.

Section 10, while it arrives at the end of the *Code*, essentially provides a framework for all the Opinions. It clarifies the basis for the

reciprocal rights and obligations on the part of physicians and patients, which helps foster a trustworthy and trusting therapeutic alliance.

The content of the entire AMA's Code of Medical Ethics is accessible online at www.ama-assn.org/go/ceja. ♦

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(Footnotes)

¹ For a more in-depth analysis of the historical significance of the Code, readers should refer to *The American Medical Ethics Revolution*, on which this explanation is based. Robert B. Baker, "The American Medical Ethics Revolution," in Robert B. Baker, Arthur L. Caplan, Linda L. Emanuel, & Stephen R. Latham, eds., *The American Medical Ethics Revolution* (Baltimore: Johns Hopkins University Press, 1999): 17-51.