

REPORTS OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS

The following reports, 1–6, were presented by Sharon P. Douglas, MD, Chair:

1. PHYSICIAN STEWARDSHIP OF HEALTH CARE RESOURCES

Reference committee hearing: see report of [Reference Committee on Amendments to Constitution and Bylaws](#).

HOUSE ACTION: RECOMMENDATIONS ADOPTED AND REMAINDER OF REPORT FILED

See Policy [H-140.847](#)

US health care spending reached 17.6 percent of gross domestic product (GDP) in 2009,[1] almost double that of other industrialized countries.[2] This level of spending presents an enormous burden for federal and state governments, businesses, families, and individuals.[2] The high cost of health care imperils access to care,[3,4] and access is likely to worsen if costs continue to outpace incomes.[5]

This report by the Council on Ethical and Judicial Affairs (CEJA) examines the role physician treatment decisions play in overall health care costs and analyzes physicians' obligation to manage health care resources wisely. It provides ethical guidance to support physicians in making fair, prudent, cost-conscious decisions for care that meet the needs of individual patients and help to ensure availability of health care for others.

The focus of the report is on physicians' recommendations and decisions in everyday situations that are often overlooked, in which physicians' choice of one among several reasonable alternatives can affect the availability of resources across the community of patients or the aggregate cost of care in the community. (For example, ordering a serum pregnancy test instead of a urine pregnancy test, which costs substantially more but for the majority of patients does not provide significant additional benefit.)

These everyday decisions are distinct from triage decisions, in which multiple patients compete for a clearly defined set of limited resources—e.g., in a pandemic or natural disaster. Decision making under such conditions has been discussed at some length in the literature and is addressed in Opinion E-9.067, "Physician Obligation in Disaster Preparedness and Response" (AMA Policy Database). Everyday choices are also distinct from "high stakes" decisions about interventions that can mean life or death for patients or forestall extremely poor outcomes, such as decisions to initiate mechanical ventilation in emergent circumstances when the patient's prognosis is uncertain. Arguably, in situations when there is significant risk of harm, cost considerations, if they play a role at all, are better addressed through collectively designed policy than left to individual decisions physicians must grapple with at the bedside.

TREATMENT DECISIONS, HEALTH CARE SPENDING & BENEFIT TO PATIENTS

Numerous factors drive the overall cost of health care, many of which are beyond the control of individual physicians. These include high administrative costs,[2,7] population trends (such as aging or obesity[2]); malpractice liability costs; patient expectations and demands; and high prices of drugs, devices, and hospital and professional services.[2,7] Other cost drivers, however, such as extensive use of new technologies[8] and high intensity of services provided at each patient encounter,[2,7] are influenced by physician choices.

Physician orders and recommendations play a significant role in determining which services and how many services patients receive; without a physician's assent clinical orders or policies generally cannot be implemented.[9] To this extent, physicians have an opportunity to affect health care spending overall. Documented regional variations in Medicare spending are explained in part by variations in physician practice patterns.[10,11] Higher spending regions and institutions have been shown to have higher intensity care, greater use of hospitals and intensive care units, and more utilization of specialists, tests, and minor procedures.[12-14] Practice differences seem to be less for interventions for which there are established guidelines, and more for the "discretionary" interventions that physicians recommend.[11]

More intensive and/or costlier services do not necessarily lead to better health outcomes.[12-17] In fact, lower spending regions appear to have better outcomes on certain measures, such as those developed by the Medicare Quality Improvement Organization.[8,10,15,17,18] In many domains, the services that yield the greatest benefits to health are not the factors that drive up costs, and the services that tend to drive up costs are not the ones that yield the greatest benefits to health, at least when measured at the population level.[18]

STEWARDSHIP AS AN OBLIGATION OF PROFESSIONAL ETHICS

Stewardship refers to the obligation to provide effective medical care through prudent management of the public and private health care resources with which physicians are entrusted.[6] This obligation flows both from the influence that physician decisions and recommendations have on health care costs and from core ethical obligations of physicians as professionals.

Physicians' primary ethical obligation, of course, is to protect and promote the well-being of individual patients (Principle VI, AMA Principles of Medical Ethics). However, it has long been recognized that physicians also have a responsibility to patients in general to promote the public health (Principle VII) and access to care for all patients (Principle IX).

Historically, medicine as a learned profession has been understood to have a social responsibility to use knowledge and skills to enhance the common good,[21-23,24] including obligations to protect public health and safety, even if this might require restricting the liberties of individual patients (Opinion E-2.25, "The Use of Quarantine and Isolation as Public Health Measures"; Opinion E-2.24, "Impaired Drivers and Their Physicians"). Similarly, the *Code of Medical Ethics* recognizes that without compromising their primary obligation, physicians should be conscious of the costs of care (Opinion E-2.09, "Costs"); that they should consider the needs of broader patient populations (Opinion E-8.054, "Financial Incentives and the Practice of Medicine"); and that they should not provide treatment that is "willfully excessive" (Opinion E-4.04, "Economic Incentives and Levels of Care"). The profession's authority rests on fulfillment of these commitments.[25]

Arguments that physicians should never allow considerations other than the welfare of the patient before them to influence their professional recommendations and treatment[19,20] do not mesh with the reality of clinical practice. Physicians regularly work with a variety of limits on care: clinical practice guidelines, patient preferences, availability of certain services, the benefits covered by a patient's insurance plan, and the time physicians and nurses can spend caring for a patient all influence what interventions physicians recommend and what care they provide.

Physicians also regularly confront the effects of uneven or unfair distribution of health care resources in their day-to-day practice. They express moral distress about having to provide different levels of care for those who are uninsured or grossly underinsured than they provide for patients with adequate insurance coverage. They witness the adverse consequences for their patients when needed resources (e.g., particular specialists, hospital beds, imaging equipment) are too scarce.[27] As frontline providers, physicians are in a position to identify unacceptably restricted resources in their community.

MAKING COST-CONSCIOUS DECISIONS

There is broad consensus that physicians should first take medical need into consideration when making recommendations and providing care. Physicians are expected to refrain from offering or acceding to patients' requests for interventions or diagnostic tests that are medically unnecessary (E-2.19, "Unnecessary Medical Services") or that cannot reasonably be expected to benefit the patient (E-2.035, "Futile Care"). Physicians are likewise expected to provide—or advocate vigorously for—interventions that will clearly benefit the patient or clearly avert significant harm. However, between these two ends of the spectrum, physicians face decisions about whether to recommend or provide interventions that offer some increment of benefit, but which perhaps pose additional risks or substantial additional financial cost.[29] It is in this grey zone of marginal benefit that principles for wise stewardship should help shape decisions about care.

Making cost-conscious decisions is not far removed from the professional judgments physicians already make. Physicians routinely decide whether interventions with small benefits are worthwhile, whether diagnostic tests need to be STAT or routine, whether a patient needs to be seen urgently or routinely, whether the public health impact of a broad spectrum antibiotic is justified for a certain infection, and whether patient requests for expensive

interventions are justified.[30-31] Reasonable criteria to guide cost-conscious decisions in routine care include the likelihood of benefit for the patient and the anticipated degree and duration of benefit, including change in quality of life (E-2.03, “Allocation of Limited Medical Resources”).

Physicians should be aware of the relative strength of the evidence for anticipated benefits. Well-designed clinical practice guidelines, such as those available through the National Guideline Clearinghouse,[32] or quality measures, such as those developed by the AMA-convened Physician Consortium for Performance Improvement® (PCPI™),[33] should provide a baseline for treatment recommendations.

But guidelines should never simply supplant professional judgment. Physicians have a responsibility to argue for the course of care they judge most appropriate for the individual patient based on the patient’s unique clinical circumstances (e.g., E-8.13, “Managed Care”; E-8.135, “Cost Containment Involving Prescription Drugs in Health Care Plans”). Even the most evidence-based guidelines cannot take into account the tremendous variety physicians encounter caring for individual patients.[28] A guideline that suggests a particular service is not “needed” may be well justified for most patients, but physicians will inevitably care for patients who qualify as legitimate, justifiable exceptions, clinically and ethically.

Similarly, for a specific patient, guidelines or standards of care might describe services that are unnecessary because of individual patient details. For example, current quality measures stipulate the frequency of lipid testing and use of lipid-lowering medication for diabetics. However, as is often mentioned in guidelines, co-morbid conditions (e.g., a life-limiting disease not related to diabetes or heart disease) can justify less testing or discontinuation of medication. Conversely, younger diabetics, who have more years in which to develop end-organ damage, might be treated more aggressively in many ways than older ones, sometimes more aggressively than guidelines (or quality measures) describe for the “average” diabetic. Likewise, screening that may be generally recommended for various cancers (especially slowly developing cancers) may have less clinical value for patients of advanced age or who have significant co-morbidities than for younger or healthier patients, for whom earlier detection and intervention may offer greater clinical benefit or may be better able to bear the burdens of treatment.[29]

When guidelines are not available, determining whether a particular intervention is worthwhile for an individual patient necessarily rests heavily on physicians’ professional judgment. Such determinations may differ from patient to patient and for an individual patient as his or her clinical situation changes. To the extent that physicians’ primary task at each patient encounter is to heal, physicians should judge the necessity of an intervention based on its ability to cure, to relieve suffering, or to cultivate health—but always to care.[34]

While the default presumption is that physicians should honor patients’ wishes with respect to treatment (E-10.01, “Fundamental Elements of the Patient-Physician Relationship”), patient values and preferences should be balanced against considerations of stewardship. Patients with health care insurance rarely face the entire cost of their care, and in any individual situation they may not recognize or value the need to restrain spending. When patients or their families argue for an intervention the physician deems to offer marginal benefit, physicians should strive to help them articulate goals for care and to help them form realistic expectations about whether the intervention is likely to achieve those goals.

For example, a particular patient or family might request off-label use of an expensive chemotherapeutic agent as an adjunct to standard therapy.[35] Physicians should be mindful that patient expectations for particular treatments or procedures can be shaped by many influences, including the advice of family and friends, online information, direct-to-consumer advertising,[36,37] and, of course, a wish to do “something” that might increase their overall survival. Many of these influences are not tailored to the patient’s immediate clinical needs, and naturally most are not sensitive to considerations of cost or fairness.

Physicians’ knowledge of what care their patients need (and how urgently they may need it), along with their firsthand experience with the consequences for patients when those needs are not met, means physicians can well appreciate the importance of allocating health care resources responsibly. In making treatment recommendations for individual patients, physicians should be aware of and consider the level of resources needed to achieve the patient’s goals. When alternative courses of action offer similar likelihood and degree of benefit but require different levels of resources, choosing the less costly course of action can help preserve resources for the benefit of patients overall (E-8.135; E-8.054, “Financial Incentives and the Practice of Medicine”).

Physicians should take the time to be transparent and honest in counseling patients about alternatives—including less costly care—instead of deferring to patients' requests for care that are not consistent with the physician's considered professional judgment. Honesty and transparency are critical to maintaining patient trust; patients are vulnerable and rely heavily on the physician's competence and good will.[38] In today's busy practice environment, it may be expedient for physicians simply to provide what a patient asks for regardless of medical need. Yet such expediency does not serve patient interests well, because it often does not lead to more efficient or higher quality care.

Physicians should make all reasonable efforts to resolve persistent disagreements about whether a particular treatment or procedure is cost worthy in the patient's situation. Physicians should consider consulting with a colleague or seeking an ethics consultation, for instance. If all efforts to resolve the disagreement fail, the patient may wish to seek care elsewhere. While it may be justifiable to terminate the patient-physician relationship, this should be a last resort and appropriate measures should be taken to ensure continuity of care (Opinions E-8.115, "Termination of the Patient-Physician Relationship"; E-8.11, "Neglect of Patient"; E-10.01, "Fundamental Elements of the Patient-Physician Relationship").[39-41] Physicians are under no obligation to provide interventions simply because patients request them (E-2.035).

OBSTACLES TO PHYSICIAN STEWARDSHIP: A ROLE FOR THE PROFESSION

Many physicians generally recognize an obligation to distribute limited resources responsibly, but struggle with when and how to take this into account when considering individual treatment decisions.[42] They face a variety of obstacles in trying to fulfill the ethical obligation to be prudent stewards, including lack of knowledge about the costs of interventions and the impact of their individual recommendations and decisions, the complexity of the systems in which health care is delivered, and concerns about potential medical liability if they fail to order a test or intervention.[43] Individual physicians cannot and should not be expected to resolve the challenges of wisely managing health care resources and rising health care costs solely "at the bedside." Medicine as a profession has an equal obligation to help create conditions for practice that make it feasible for physicians to be prudent and trustworthy stewards.

Physicians need to be knowledgeable about health care costs and how their individual decisions can affect overall health care spending (Policy H-155.998, "Voluntary Cost Containment"). Education for medical students and practicing physicians alike should include discussion of costs. Physicians also need to understand how their individual decisions affect institutional resources in the aggregate. Health care administrators and organizations should make costs transparent to participating physicians to enable them to make well-informed decisions as stewards.

Other systemic factors, such as the perceived need to practice "defensive medicine," also work to undermine stewardship. The professional responsibility and ethical duty to practice medicine in a manner that is respectful of the finite nature of health care resources does not confer a legal duty to withhold or administer any particular treatment or diagnostic procedure. Rather, responsible stewardship upholds the principle that clinical expertise should be integrated with the best information from scientifically based, systematic research and applied in light of the patient's values and circumstances.[26] Medicine as a profession has an important role to play in advocating for policies that address concerns about medical liability and other systemic factors that impede responsible stewardship.

Every physician must be able to trust that the colleagues to whom he or she refers patients will exercise prudent stewardship in making recommendations about a patient's care. Given the complex structures in which health care is now delivered, responsible stewardship by one will have little overall effect if responsible stewardship is not practiced by all. Medicine must commit itself to nurturing a culture of accountability, in which health care expenditures are directed toward providing high quality care to meet the needs of individual patients in ways that preserve resources to enable physicians to better meet the needs of all.

RECOMMENDATION

The Council on Ethical and Judicial Affairs recommends that the following be adopted and the remainder of this report be filed:

Physicians' primary ethical obligation is to promote the well-being of individual patients. Physicians also have a long-recognized obligation to patients in general to promote public health and access to care. This obligation requires physicians to be prudent stewards of the shared societal resources with which they are entrusted. Managing health care resources responsibly for the benefit of all patients is compatible with physicians' primary obligation to serve the interests of individual patients.

To fulfill their obligation to be prudent stewards of health care resources, physicians should:

- (a) Base recommendations and decisions on patients' medical needs;
- (b) Use scientifically grounded evidence to inform professional decisions when available;
- (c) Help patients articulate their health care goals and help patients and their families form realistic expectations about whether a particular intervention is likely to achieve those goals;
- (d) Endorse recommendations that offer reasonable likelihood of achieving the patient's health care goals;
- (e) Choose the course of action that requires fewer resources when alternative courses of action offer similar likelihood and degree of anticipated benefit compared to anticipated harm for the individual patient, but require different levels of resources;
- (f) Be transparent about alternatives, including disclosing when resource constraints play a role in decision making; and
- (g) Participate in efforts to resolve persistent disagreement about whether a costly intervention is worthwhile, which may include consulting other physicians, an ethics committee, or other appropriate resource.

Physicians are in a unique position to affect health care spending. But individual physicians alone cannot and should not be expected to address the systemic challenges of wisely managing health care resources. Medicine as a profession must create conditions for practice that make it feasible for individual physicians to be prudent stewards by:

- (h) Encouraging health care administrators and organizations to make cost data transparent (including cost accounting methodologies) so that physicians can exercise well-informed stewardship;
- (i) Ensuring that physicians have the training they need to be informed about health care costs and how their decisions affect overall health care spending; and
- (j) Advocating for policy changes, such as medical liability reform, that promote professional judgment and address systemic barriers that impede responsible stewardship.

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2. JUDICIAL FUNCTION OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS: ANNUAL REPORT

Informational report. No reference committee hearing.

HOUSE ACTION: FILED

At the 2003 Annual Meeting, the Council on Ethical and Judicial Affairs (CEJA) presented a detailed explanation of its judicial function. This undertaking was motivated in part by the considerable attention professionalism has received in many areas of medicine, including the concept of professional self-regulation.

CEJA has authority under the Bylaws of the American Medical Association (AMA) to disapprove a membership application or to take action against a member. The disciplinary process begins when a possible violation of the *Principles of Medical Ethics* or illegal or other unethical conduct by an applicant or member is reported to the AMA. This information most often comes from statements made in the membership application form, a report of disciplinary action taken by state licensing authorities or other membership organizations, or a report of action taken by a government tribunal.

The Council rarely re-examines determinations of liability or sanctions imposed by other entities. However, it also does not impose its own sanctions without first offering a hearing to the physician. CEJA can impose the following sanctions: applicants can be accepted into membership without any condition, placed under monitoring, or placed on probation. They also may be accepted but be the object of an admonishment, a reprimand, or censure. In some cases, their application can be rejected. Existing members similarly may be placed under monitoring or on probation, and can be admonished, reprimanded or censured. Additionally, their membership may be suspended or they may be expelled. Updated rules for review of membership can be found at <http://www.ama-assn.org/ama/pub/about-ama/our-people/ama-councils/council-ethical-judicial-affairs/governing-rules/rules-review-membership.page>.

Beginning with the 2003 report, the Council has provided an annual tabulation of its judicial activities to the House of Delegates. In the appendix to this report, a tabulation of CEJA's activities during the most recent reporting period is presented.

CEJA Judicial Function Statistics, April 1, 2011 ~ March 31, 2012

Physicians Reviewed	SUMMARY OF CEJA ACTIVITIES
4	Determination of no probable cause
52	Final determinations following a plenary hearing (<i>including no action taken</i>)
21	Final determinations without a plenary hearing (<i>hearing affirmatively waived, offer of compromise accepted, non-compliance with probationary/monitoring requirements, resignation accepted, or non-response to the offer of a hearing</i>)

Physicians Reviewed	FINAL DETERMINATION (by type of action taken)
11	No sanction or other type of action
5	Monitoring
17	Probation
14	Revocation
2	Suspension
1	Resignation accepted
1	Application denied
22	Censure/Admonishment/Reprimand

Physicians Reviewed	PROBATION/MONITORING STATUS
22	Members placed on Probation/Monitoring during reporting interval
12	Members placed on Probation without reporting to the NPDB.
10	Probation/Monitoring concluded satisfactorily during reporting interval
75	Number of physicians on Probation/Monitoring at any time during reporting interval

Physicians Reviewed	REPORTS TO AMA STAFF OF POSSIBLE ETHICAL VIOLATIONS
30	Physicians under consideration by AMA staff for possible notification at end of reporting interval
125	Approximate number of physicians reviewed who were not brought to CEJA's attention.

3. CEJA'S SUNSET REVIEW OF 2002 HOUSE POLICIES

Reference committee hearing: see report of [Reference Committee on Amendments to Constitution and Bylaws](#).

HOUSE ACTION: RECOMMENDATIONS ADOPTED AND REMAINDER OF REPORT FILED

At its 1984 Interim Meeting, the House of Delegates (HOD) established a sunset mechanism for House policies (Policy G-600.110, AMA Policy Database). Under this mechanism, a policy established by the House ceases to be viable after 10 years unless action is taken by the House to retain it.

The objective of the sunset mechanism is to help ensure that the AMA Policy Database is current, coherent, and relevant. By eliminating outmoded, duplicative, and inconsistent policies, the sunset mechanism contributes to the ability of the American Medical Association (AMA) to communicate and promote its policy positions. It also contributes to the efficiency and effectiveness of HOD deliberations.

At its 2002 Annual Meeting, the House modified Policy G-600.110 to change the process through which the policy sunset review is conducted. The process now includes the following steps:

- In the spring of each year, the House policies that are subject to review under the policy sunset mechanism are identified.
- Using the areas of expertise of the AMA Councils as a guide, the staffs of the AMA Councils determine which policies should be reviewed by which Councils.
- For the Annual Meeting of the House, each Council develops a separate policy sunset report that recommends how each policy assigned to it should be handled. For each policy it reviews, a Council may recommend one of the following actions: (a) retain the policy; (b) rescind the policy; or (c) retain part of the policy. A justification must be provided for the recommended action on each policy.
- The Speakers assign the policy sunset reports for consideration by the appropriate Reference Committees.

Although the policy sunset review mechanism may not be used to change the meaning of AMA policies, minor editorial changes can be accomplished through the sunset review process.

2002 POLICIES

In this report, the Council on Ethical and Judicial Affairs presents its recommendations regarding the disposition of 2002 House policies that were assigned to or originated from CEJA.

DUPLICATIVE POLICIES

On the model of the Council on Long Range Planning & Development (CLRPD)/CEJA Joint Report (I-01) and of subsequent reports of CEJA's sunset review of House policies, this report recommends the rescission of House policies that originate from CEJA Reports and duplicate current opinions issued since June 2005. As noted previously, the intent of this process is the elimination of duplicative ethics policies from PolicyFinder. The process does not diminish the substance of AMA policy in any sense. Indeed, CEJA Opinions are a category of AMA policy.

MECHANISM TO ELIMINATE DUPLICATIVE ETHICS POLICIES

The Council continues to present reports to the HOD. If adopted, the recommendations of these reports continue to be recorded in PolicyFinder as House policy. After the corresponding CEJA Opinion is issued, CEJA utilizes its annual sunset report to rescind the duplicative House policy.

For example, at the 2007 Interim Meeting, the HOD adopted the recommendations of CEJA Report 8-I-07, "Pediatric Decision-Making." It was recorded in PolicyFinder as Policy H-140.865. At the 2008 Annual Meeting, CEJA filed the corresponding Opinion E-2.026, thereby generating a duplicative policy. Under the mechanism to eliminate duplicative ethics policies, CEJA recommended the rescission of Policy H-140.865 as part of the Council's 2009 sunset report.

The Appendix provides recommended actions and their rationale on House policies from 2002, as well as on duplicate policies.

RECOMMENDATION

The Council on Ethical and Judicial Affairs recommends that the House of Delegates policies that are listed in the Appendix to this report be acted upon in the manner indicated and the remainder of this report be filed.

APPENDIX - Recommended Actions

Policy No.	Title	Recommended Action & Rationale
H-370.982	Ethical Considerations in the Allocation of Organs and Other Scarce Medical Resources Among Patients	Retain: Policy remains relevant
H-370.975	Ethical Issues in the Procurement of Organs Following Cardiac Death	Retain: Policy remains relevant
H-270.963	Organ Donation	Rescind: Policy no longer relevant

4. NOMINATION FOR AFFILIATE MEMBERSHIP

No reference committee hearing; adopted during general session Sunday, June 17.

HOUSE ACTION: RECOMMENDATION ADOPTED AND REMAINDER OF REPORT FILED

In keeping with Bylaw 1.12, Affiliate Members, the Council on Ethical and Judicial Affairs recommends the following individuals for affiliate membership in the American Medical Association (AMA):

Individuals Who Have Attained Distinction in Their Field of Endeavor

Litjen Tan, PhD

As Director of Medicine and Public Health in the Science, Quality, and Public Health area, Dr. Tan has made extensive contributions to the AMA, its members, and the Federation. Dr. Tan is a nationally recognized leader in adult and influenza immunization policy. His group heads a variety of AMA public health initiatives including the Commission to End Health Care Disparities, Federation of State Physician Health Programs, Building a Healthier Chicago, and Environmental Protection Agency tobacco grants. He has authored extensive reports on public health, vaccines, and infectious disease for both the Board of Trustees and Council on Science and Public Health. Dr. Tan has been honored with several advocacy awards, including the American Pharmacists Association's 2009 Immunization Champion award. He is active in a professional societies, has been appointed to a number of national working groups and councils, is frequently invited for speaking and panelist engagements, and is widely published in peer-review journals, including *JAMA*, *Pediatrics*, and *Archives of Internal Medicine*. Dr. Tan's tenure at the AMA began with a director position in Infectious Disease, Immunology, and Molecular Medicine in 1997. He became Director of Medicine in Public Health in 2008.

Barry Dickinson, PhD

As Secretary for the Council on Science and Public Health and Director of Science and Biotechnology, Dr. Dickinson has made extensive contributions to the AMA, its members, and the Federation. Dr. Dickinson provides leadership for AMA medical science initiatives including CME programs and Board of Trustees reports, particularly in the areas of molecular medicine, pharmacogenomics, and genetics. Dr. Dickinson has significantly influenced AMA policy by preparing over 100 Council on Science and Public Health (CSAPH) reports, many of which have been accepted for publication in peer-review journals including *JAMA* and *Archives of Internal Medicine*. Dr. Dickinson's work is widely published in book chapters and peer-reviewed journals, and he has served on numerous external boards and expert panels. Since 1989, Dr. Dickinson has held several roles in editing and science at the AMA and began his work in the Science, Quality, and Public Health area in 1997.

5. PHYSICIAN RESPONSIBILITIES FOR SAFE PATIENT DISCHARGE FROM HEALTH CARE FACILITIES

Reference committee hearing: see report of [Reference Committee on Amendments to Constitution and Bylaws](#).

HOUSE ACTION: RECOMMENDATIONS ADOPTED AND REMAINDER OF REPORT FILED

See Policy [H-140.846](#)

Physicians' ethical obligation to promote the well-being of patients includes the obligation to collaborate with other health care professionals to develop discharge plans that are safe for patients. The discharge plan should be developed without regard to the patient's socioeconomic status, immigration status, or other clinically irrelevant considerations. At the same time, physicians also have an obligation to be prudent stewards of the societal resources with which they are entrusted. In discharge planning, physicians must balance their obligation to advocate for individual patients with recognition of the needs of others. This report examines physicians' ethical obligations for discharging patients safely, including implications for discharge practices in contexts of limited options.

PHYSICIANS' ETHICAL RESPONSIBILITIES IN DISCHARGING PATIENTS

When a patient discharge from a health care facility is planned, the physician must evaluate its appropriateness. Therefore, a patient discharge should not occur without the physician's prior order. In patient discharge, the following statement by Pellegrino holds true: "No order can be carried out, no policy observed, and no regulation imposed without the physician's assent.... The physician is therefore de facto a moral accomplice in whatever is done for good or ill to patients."^[1]

In considering and making discharge decisions, physicians are guided by a framework that prioritizes the well-being of patients. The physician's fundamental purpose is to help alleviate the impact of illness on human persons.^[2] Therefore, dedication to patients' well-being is not only a basic tenet of a physician's professional ethic,^[3-6] it is a physician's primary ethic. Principle VIII of the AMA Principles of Medical Ethics affirms, "A physician shall, while caring for a patient, regard responsibility to the patient as paramount" (AMA Policy Database).^[5]

With regard to a patient discharge decision, this primary ethic requires that the physician be satisfied that the discharge plan appropriately meets the individual patient's medical needs and is safe for the patient. A safe patient discharge is an ethical standard which acknowledges that discharge arrangements are often complex,^[7] involving numerous stakeholders and concerns that are beyond a physician's control.^[8,9] By way of example, a model discharge may favor a professional caretaker who is available 24 hours a day, when in reality the only available caretaker may be obligated elsewhere and be able to meet only the patient's minimum needs for having a caregiver available. Safe discharge requires that physicians, together with the assistance of institutional support staff if needed, weigh such practical realities in light of the patient's best interests and take reasonable steps to prevent foreseeable harm to the patient during and after the discharge.

The safety of patients depends on physicians (and supporting staff) anticipating and addressing (or delegating others to address) risks before authorizing a discharge, which is when physicians have some control over the process. Many risks will be clinical in nature, but physicians may be able to anticipate and address psychosocial and situational

risks as well.[10] Regardless of clinical stability at the time of discharge, risks of harm can escalate if patients are, for instance, socially isolated, left without appropriate caretakers, or forced to live in an unsuitable environment after discharge.[8,9] Therefore, to ensure safety, physicians, in partnership with other health care professionals,[10] should confirm the patient's clinical readiness for discharge, confirm the receiving environment's appropriateness to meet the patient's needs, respect caretakers' concerns and patients' preferences, and be sensitive to societal interests to the extent possible.

Confirm the Patient's Clinical Readiness for Discharge

According to standard practice and consistent with his or her expertise, the physician should carefully assess the patient and confirm that the individual is medically stable enough to leave the hospital setting and to travel distances (if the planning anticipates this) before authorizing a discharge.[11] Whether a patient is medically stable for discharge may depend on specific discharge arrangements. Physicians should be satisfied that aspects of discharge arrangements—such as transportation, care during transportation, and appropriate, sustainable care at the destination—have been reasonably verified either by themselves or by other available hospital professionals who have relevant expertise. While discharge coordinators or others may be better equipped to make these arrangements,[7,12] the physician should always clarify to all involved parties the expectations regarding a patient's needs, including the minimum technological capabilities and the provider expertise necessary to deliver an appropriate level of care. Expectations regarding accountability for execution of the plan should also be stipulated.

Confirm the Receiving Environment's Ability to Meet the Patient's Needs

A physician's responsibility for safe patient discharge is recognized as standard practice, and the responsibility has been affirmed through several formal means. As a condition of participation in Medicare and Medicaid services, hospitals are required to discharge patients to "appropriate facilities" that can sufficiently meet the patient's medical needs.[13] The AMA Council on Scientific Affairs (now Council on Science and Public Health) in its 1996 report on evidence-based discharge practices affirmed as a primary principle that a patient's needs "be matched to an environment with the ability to meet those needs." [10]

Physicians should not discharge a patient to an environment in which the patient's health could reasonably be expected to deteriorate due solely to inadequate resources at the intended destination. Before discharging a patient, the physician should be assured that both the professional and material resources at the receiving facility are adequate to address the patient's medical needs.[7,12] While a discharging physician may have no control over the care provided at the destination, he or she is nonetheless well placed to decide whether the described standard of care at the destination is likely to be appropriate for the patient's post-discharge care needs. To do so, the physician (or assigned discharge professionals) should work cooperatively with discharge planning staff at the transferring facility to coordinate with caretakers at the receiving facility.

In an effort to secure appropriate continuity of patient care, physicians may also request that discharge plans stipulate follow-up progress reports on a discharged patient. Such follow-up may be effective in preventing unplanned rehospitalizations.[14] It may also allow the physician and others to consider corrective steps when the new care setting belatedly proves to be unsafe for the patient. At the very least, such follow-up may help prevent harm to future patients who may be discharged to the same facility under similar conditions.

Respect Caretakers' Concerns and Patients' Preferences

Physicians should actively seek the input of the patient's future caretakers and respect their concerns when possible. Discharge is by nature a complex process that involves multiple concerned individuals making negotiated arrangements for the patient's care.[8] Not only are future caretakers, such as family members, significantly affected by the changes that a patient's discharge often entails,[8] but their availability to provide care is vital to the patient's long-term safety. A discharge is more likely to serve the future well-being of the patient if it accounts for others' ability, availability, and willingness to provide long-term care. Future caretakers' knowledge of the financial and community resources may also be helpful to physicians as they consider the patient's care needs following discharge.

Similarly, individual patients' own informed preferences regarding discharge and post-discharge care arrangements should be respected by physicians whenever possible. In so doing, physicians help to mitigate harms that arise from

an undue constraint on one's ability to exercise self determination. This responsibility is widely affirmed in various opinions of the AMA's *Code of Medical Ethics*. [15-19]

The physician's responsibility to respect a patient's right to self-determination acknowledges that the right is not absolute, [20] but that it is appropriately constrained, in some measure, by the options afforded by a multiplicity of other social factors. Physicians should consider the wishes of the patient to the extent that respecting a patient's right to self-determination contributes to a safe discharge. Discharge often marks a significant medical and social transition for patients. While some patients fully recover and return to the normalcy of home, many with ongoing care needs enter a new phase of care at home or another health care facility. For this group in particular, discharge is often marked by the stresses of adjusting to new care and living arrangements. [8] By providing patients with a degree of control over this process, physicians can help patients better prepare for a safer transition.

Be Sensitive to Societal Interests

Physicians should be sensitive to the interests of society in discharge practices, but without compromising the individual patient's safety, which must remain a physician's primary commitment. The patient-physician interaction necessarily exists within a nexus of specific policies and limited resources. This reality shapes what a physician is or is not able to do in regard to patient discharge. For example, the unsustainable costs of health care in the US have made the prudent use of health care resources increasingly important. Many health care institutions incentivize reducing a patient's length of stay, for instance, in an effort to constrain costs. [21] Such incentives, while legitimate, may increase the risk of patients being discharged before they are clinically ready or before post-discharge care can be adequately arranged. Physicians should be wary of such possibilities and should avoid the influence of nonclinical elements during discharge planning, because nonclinical factors can compromise the safety of patients.

IMPLICATIONS FOR DISCHARGE TO RESOURCE POOR SETTINGS

Ensuring a safe discharge for patients can be extremely challenging for physicians when adequate post-discharge options are severely limited. For instance, homeless patients may have limited options due to a lack of insurance or caretakers, [22] while a patient in a rural setting may be limited by logistic barriers. The issue of limited options is starkly illustrated by recent reports alleging forced discharge of noncitizen immigrant patients from US hospitals to resource poor facilities in their countries of origin.

Physicians should, of course, assess the patient's medical stability and readiness for discharge to another care environment and for a long international trip (during which patients may be prone to dehydration or respiratory illness [23]). Relative to a local discharge, an international discharge may require additional efforts to coordinate care effectively, such as speaking with the receiving physician through an interpreter or seeking reliable information about the standard of care at the facility in question. For patients with extensive care needs, the physician should keep in mind that many countries throughout the world are struggling to provide even basic medical care for their citizens, and are unlikely to be able to provide resource intensive care with public funds. [24] Regardless of whether or not the discharging hospital itself is the best environment for the patient's needs, [25] the physician should not discharge the patient to care conditions that are inadequate to his or her needs.

Throughout the discharge process, physicians should listen to the concerns of future caretakers and to the preferences of a patient who is not a citizen or legal resident just as they would when planning the discharge of a citizen patient. The physician should consider the caretakers' and patient's understanding of the standards of care in their country of citizenship and the social attachments (such as employment or other support systems) that the patient may have in the US, for example. These considerations may be important when physicians assess the adequacy of future care arrangements for the patient. Moreover, the caretakers' and patient's involvement in the discussions may very well lead to a helpful consensus about what ought to be done.

Despite efforts to fulfill all the responsibilities of a safe discharge practice, in the end, physicians may be unable to make an ethically satisfying decision. Even if a patient is medically ready for discharge and administrators insist that an adequate facility is available, patients and their families may continue to object, thereby creating a stalemate situation. Physicians should then support the patient's right to seek input from an ethics committee that is independent from the hospital's administrative functions. Should consensus fail even after such input, a physician should support a patient's right to seek arbitration before a legal body. [26] Forcing an immigrant to leave the US is a prerogative of the federal government, and should only occur following due process. [26,27] Physicians should

decline to authorize a discharge that would result in the patient's involuntary repatriation, except pursuant to legal process.

RESPONSIBILITY TO SUPPORT SAFE DISCHARGE ENABLING POLICIES

The challenges associated with discharging uninsured or immigrant patients with long-term post-hospital needs are complex. Resolving this issue will require the collective involvement of various stakeholders in health care, including physicians, health care facilities, insurers, policymakers, and the public.[28] Physicians should participate in the policy development process by supporting proposals that will benefit patients and are consistent with the ethical principles on which the medical profession is established. They should work to ensure that societal decisions about discharge and long-term care safeguard the interests of all patients,[29] including patients who are socially, politically, and economically disadvantaged.

RECOMMENDATION

The Council recommends that the following be adopted and the remainder of this report be filed:

Physicians' primary ethical obligation to promote the well-being of individual patients encompasses an obligation to collaborate in a discharge plan that is safe for the patient. As advocates for their patients, physicians should resist any discharge requests that are likely to compromise a patient's safety. The discharge plan should be developed without regard to socioeconomic status, immigration status, or other clinically irrelevant considerations. Physicians also have a long-standing obligation to be prudent stewards of the shared societal resources with which they are entrusted. That obligation may require physicians to balance advocating on behalf of an individual patient with recognizing the needs of other patients.

To facilitate a patient's safe discharge from an inpatient unit, physicians should:

- (a) Determine that the patient is medically stable and ready for discharge from the treating facility; and
- (b) Collaborate with those health care professionals and others who can facilitate a patient discharge to establish that a plan is in place for medically needed care that considers the patient's particular needs and preferences.

If a medically stable patient refuses discharge, physicians should support the patient's right to seek further review, including consultation with an ethics committee or other appropriate institutional resource.

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6. AMENDMENT TO E-9.011, “CONTINUING MEDICAL EDUCATION”

Reference committee hearing: see report of [Reference Committee on Amendments to Constitution and Bylaws](#).

HOUSE ACTION: REFERRED

Ethics policy relating to continuing medical education (CME), Opinion E-9.011, “Continuing Medical Education” (AMA Policy Database), was last updated in 1996. Since then, CME has evolved substantially, as have standards for the conduct of CME providers, such as those of the Accreditation Council for Continuing Medical Education. In addition, CEJA Report I-A-11, “Financial Relationships with Industry in Continuing Medical Education,” adopted in June 2011 and subsequently Opinion E-9.0115 of the same title, bears on these matters.

In light of these developments, the Council on Ethical and Judicial Affairs has reviewed prior policy and concluded that Opinion E-9.011 should be updated.

KEY REVISIONS

The Council reviewed Opinion E-9.011 with the goal of ensuring consistency among Opinions in the *Code of Medical Ethics*, avoiding unnecessary repetition of guidance set out in AMA policies and other standards for CME, and providing succinct ethical guidance that physicians can readily apply across the evolving spectrum of CME. Revisions, developed in consultation with the Council on Medical Education, are directed toward clearly focusing

on ethical guidance for physician-attendees of certified CME activities and eliminating ethical guidance specifically directed to other audiences.

Guidelines for physician-attendees (section one of current Opinion E-9.011) have been edited for clarity, including replacing cross-references to Opinion E-8.061, "Gifts to Physicians from Industry," with explicit guidance regarding subsidies for expenses of attending CME activities.

Guidelines for faculty (section two of current Opinion E-9.011) overlap with requirements established elsewhere, including

- Opinion E-9.0115, Financial Relationships with Industry in Continuing Medical Education;
- Accreditation Criteria, Standards for Commercial Support and related policies of the Accreditation Council for Continuing Medical Education;
- Guidance on industry-supported educational activities from the US Food and Drug Administration; and
- Code on Interactions with Healthcare Professionals of Pharmaceutical Research and Manufacturers of America

The guidelines in this section, including specific references to guidance from other entities, have therefore been removed from the opinion.

Similarly, guidelines for sponsors (section three of current Opinion E-9.011) overlap with requirements established in other policy, including

- Opinion E-9.0115, Financial Relationships with Industry in Continuing Medical Education;
- Accreditation Criteria, Standards for Commercial Support and related policies of the Accreditation Council for Continuing Medical Education;
- Code for Interactions with Companies from the Council of Medical Specialty Societies;
- Guidance on industry-supported educational activities from the US Food and Drug Administration; and
- Code on Interactions with Healthcare Professionals of Pharmaceutical Research and Manufacturers of America.

The guidelines in this section, including specific references to guidance from other entities, have therefore been removed from the opinion.

RECOMMENDATION

Given these considerations, the Council recommends that Opinion E-9.011, "Continuing Medical Education" (Appendix) be amended by substitution as follows and that the remainder of this report be filed:

Physicians should strive to further their medical education throughout their careers, to ensure that they serve patients to the best of their abilities and live up to professional standards of excellence.

Participating in formal continuing medical education (CME) activities is critical to fulfilling this professional commitment to lifelong learning. As attendees of CME activities, physicians should:

- (a) Select activities that are of high quality and are appropriate for the physician's educational needs.
- (b) Choose activities that are carried out in keeping with ethical guidelines and applicable professional standards.
- (c) Claim credit commensurate with the actual time spent attending a CME activity or in studying a CME enduring material.
- (d) Decline any subsidy for the expenses of participating in a CME activity from a commercial entity that has a financial interest in physicians' clinical recommendations.

APPENDIX - E-9.011, "Continuing Medical Education"

Physicians should strive to further their medical education throughout their careers, for only by participating in continuing medical education (CME) can they continue to serve patients to the best of their abilities and live up to professional standards of excellence.

Fulfillment of mandatory state CME requirements does not necessarily fulfill the physician's ethical obligation to maintain his or her medical expertise.

Attendees. Guidelines for physicians attending a CME conference or activity are as follows:

- (1) The physician choosing among CME activities should assess their educational value and select only those activities which that are of high quality and appropriate for the physician's educational needs. When selecting formal CME activities, the physician should, at a minimum, choose only those activities that (a) are offered by sponsors accredited by the Accreditation Council for Continuing Medical Education (ACCME), the American Academy of Family Physicians (AAFP), or a state medical society; (b) contain information on subjects relevant to the physician's needs; (c) are responsibly conducted by qualified faculty; (d) conform to Opinion 8.061, "Gifts to Physicians from Industry."
- (2) The educational value of the CME conference or activity must be the primary consideration in the physician's decision to attend or participate. Though amenities unrelated to the educational purpose of the activity may play a role in the physician's decision to participate, this role should be secondary to the educational content of the conference.
- (3) Physicians should claim credit commensurate with only the actual time spent attending a CME activity or in studying a CME enduring material.
- (4) Attending promotional activities put on by industry or their designees is not unethical as long as the conference conforms to Opinion 8.061, "Gifts to Physicians from Industry," and is clearly identified as promotional to all participants.

Faculty. Guidelines for physicians serving as presenters, moderators, or other faculty at a CME conference are as follows:

- (1) Physicians serving as presenters, moderators, or other faculty at a CME conference should ensure that
 - (a) research findings and therapeutic recommendations are based on scientifically accurate, up-to-date information and are presented in a balanced, objective manner;
 - (b) the content of their presentation is not modified or influenced by representatives of industry or other financial contributors, and they do not employ materials whose content is shaped by industry. Faculty may, however, use scientific data generated from industry-sponsored research, and they may also accept technical assistance from industry in preparing slides or other presentation materials, as long as this assistance is of only nominal monetary value and the company has no input in the actual content of the material.
- (2) When invited to present at non-CME activities that are primarily promotional, faculty should avoid participation unless the activity is clearly identified as promotional in its program announcements and other advertising.
- (3) All conflicts of interest or biases, such as a financial connection to a particular commercial firm or product, should be disclosed by faculty members to the activity's sponsor and to the audience. Faculty may accept reasonable honoraria and reimbursement for expenses in accordance with Opinion 8.061, "Gifts to Physicians from Industry."

Sponsors. Guidelines for physicians involved in the sponsorship of CME activities are as follows:

- (1) Physicians involved in the sponsorship of CME activities should ensure that

- (a) the program is balanced, with faculty members presenting a broad range of scientifically supportable viewpoints related to the topic at hand;
 - (b) representatives of industry or other financial contributors do not exert control over the choice of moderators, presenters, or other faculty, or modify the content of faculty presentations. Funding from industry or others may be accepted in accordance with Opinion 8.061, "Gifts to Physicians from Industry."
- (2) Sponsors should not promote CME activities in a way that encourages attendees to violate the guidelines of the Council on Ethical and Judicial Affairs, including Opinion 8.061, "Gifts to Physicians from Industry," or the principles established for the AMA's Physician Recognition Award. CME activities should be developed and promoted consistent with guideline 2 for Attendees.
 - (3) Any non-CME activity that is primarily promotional must be identified as such to faculty and participants, both in its advertising and at the conference itself.
 - (4) The entity presenting the program should not profit unfairly or charge a fee which is excessive for the content and length of the program.
 - (5) The program, content, duration, and ancillary activities should be consistent with the ideals of the AMA CME program.

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