Opinion 1.1.1 Patient-Physician Relationships

The practice of medicine, and its embodiment in the clinical encounter between a patient and a physician, is fundamentally a moral activity that arises from the imperative to care for patients and to alleviate suffering. The relationship that emerges between a patient and a physician must be based on trust. The physician's obligation to be trustworthy entails additional ethical duties such as a commitment to act for the good of patients; to uphold respect for patients as persons; to develop good communication skills; and to be professionally competent. This trust is fostered by physicians' ethical responsibilities to place patients' welfare above the physician's own self-interest or obligations to others, to use sound medical judgment on patients' behalf, and to advocate for their patients' welfare. When external influences negatively impact this trust, or the patient-physician relationship directly, physicians individually and collectively should advocate for changes to ameliorate the situation and promote a more hospitable environment in which patient-physician relationships may flourish.

A patient-physician relationship commences when a physician begins to serve a patient's medical needs. The contexts that may lead to a patient-physician relationship vary: they generally occur as a response to a request by a patient or a patient's surrogate, but can also include certain contractual, legally mandated, or emergency settings without the explicit request or consent of the patient.

While the patient-physician relationship may involve one patient and one physician in today's complex health care system, such relationships often involve multiple members of a care team, patient family members and surrogates. The core values of the patient-physician relationship, however, remain unchanged. How these values are implemented will depend on many factors, including the setting, the needs of the patient, the duration of the relationship, and the training, expertise, and experience of the physician, and will necessarily reflect the myriad ways that patients and physicians interact. While every patient-physician relationship will be different and will change over time, the fundamental importance of establishing and sustaining trust through respect for persons, good communication, and professional competency will always be crucial at every layer, node, and time of the relationship. It is the duty of physicians, therefore, to uphold these values and support patients and the primacy of the patient-physician relationship to the best of their ability in all practice settings and at all times

AMA Principles of Medical Ethics: I,II,IV,VIII

Background report(s):

CEJA Report 1-I-25, Amendment to Opinion 1.1.1 "Patient-Physician Relationships"
CEJA Report 3-A-16, Modernized *Code of Medical Ethics*
CEJA Report 1-A-01, The Patient-Physician Relationship

REPORT 01 OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS (I-25)
Amendment to Opinion 1.1.1 “Patient-Physician Relationships”

EXECUTIVE SUMMARY

The Council on Ethical and Judicial Affairs (CEJA) believes that the AMA *Code of Medical Ethics* and the profession would be well served by amending guidance to provide a more robust discussion of the nature of patient-physician relationships and physicians’ associated ethical obligations. Indeed, the practice of medicine has changed in ways that demand a thorough review and potential reconceptualization of the obligations of both individual physicians and the profession as a whole. Ultimately, Opinion 1.1.1 “Patient-Physician Relationships” must move beyond the current language that focuses on when a patient-physician relationship begins in order to more fully address how to ethically and justly sustain the relationship. Furthermore, knowing that the practice of medicine will continue to change and that as a result, so too will patient-physician relationships, the *Code* needs to clearly acknowledge that patient-physician relationships are inherently dynamic, contextual, and will continue to evolve. In light of these considerations, CEJA recommends amending Opinion 1.1.1.

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS

CEJA Report 01-I-25*

Subject: Amendment to Opinion 1.1.1 "Patient-Physician Relationships"

Presented by: Rebecca Brendel, MD, Chair

Referred to: Reference Committee on Ethics and Bylaws

The Council on Ethical and Judicial Affairs (CEJA) believes that the AMA *Code of Medical Ethics* and the profession would be well served by amending guidance to provide a more robust discussion of the nature of patient-physician relationships and physicians' associated ethical obligations. Indeed, the practice of medicine has changed in ways that demand a thorough review and potential reconceptualization of the obligations of both individual physicians and the profession as a whole.

At the 2025 Annual Meeting, testimony was heard that CEJA Report 06-A-25, "Amendment to Opinion 1.1.1 'Patient-Physician Relationships'," does not address "political and administrative influence" on the patient-physician relationship, and the report was referred back to CEJA.

In light of these considerations, CEJA has amended the body of the report and the recommendations to better reflect the reality of these external influences. As the first opinion of the *Code*, Opinion 1.1.1 is the foundation that supports all other *Code* opinions, many of which also address the important issues raised by the House. As the foundational opinion, Opinion 1.1.1 ought not be exhaustive and is not designed to address all of the important issues in the opinions that ultimately rely upon it.

BACKGROUND

Relevant House Policies

Several House policies reference the importance of the patient-physician relationship. Though not an exhaustive list, the following policies capture the spirit of the patient-physician relationship expressed within AMA House policy: H-165.837 "Protecting the Patient-Physician Relationship", H-225.950 "AMA Principles for Physician Employment", and H-275.937 "Patient/Physician Relationship and Medical Licensing Boards".[1–3] The patient-physician relationship as expressed by these policies is understood to be fundamental and paramount to the practice of medicine. This relationship is understood to carry certain obligations for physicians, including the duty to be patient advocates, to prioritize patient care, and be transparent regarding cost-sharing arrangements. Other considerations, including personal financial concerns, are to be secondary to the relationship. Furthermore, this relationship is not perceived as purely contractual, as termination of employment does not necessarily end the relationship between a physician and persons under their care (H-225.950).

* Reports of the Council on Ethical and Judicial Affairs are assigned to the Reference Committee on Ethics 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.

Relevant Code Provisions

Within the AMA *Code of Medical Ethics*, the patient-physician relationship is understood as: "fundamentally a moral activity that arises from the imperative to care for patients and to alleviate suffering[… that is] based on trust" (Opinion 1.1.1).[4] This relationship is primarily represented as emerging from a physician's fiduciary duty to patients, in which both parties enter into this fiduciary relationship via a consensual agreement. Though not an exhaustive list, the following opinions capture the spirit of the patient-physician relationship expressed within the *Code*: Opinion 1.1.1 "Patient-Physician Relationships", Opinion 1.1.3 "Patient Rights", Opinion 1.1.5 "Terminating a Patient-Physician Relationship", Opinion 1.1.6 "Quality", Opinion 1.1.7 "Physician Exercise of Conscience", Opinion 8.6 "Promoting Patient Safety".[4–9] These opinions demonstrate that the patient-physician relationship entails fiduciary responsibility, mutual respect, support for the continuity of care, open communication, quality care, and trust.

In addition, the *Code* offers several opinions that highlight the importance of minimizing outside influence on the patient-physician relationship, such as political or administrative pressures that might negatively impact the relationship. Opinion 3.1.1 "Privacy in Health Care"[10] and Opinion 3.2.1 "Confidentiality"[11] underscore the importance of respecting patients' privacy and confidentiality in all clinical settings and the fundamental importance of doing so to maintain trust in the patient-physician relationship. Similarly, Opinion 11.1.1 "Defining Basic Health Care" states that physicians, both individually and collectively, share an obligation to "advocate for fair, informed decision making about basic health care that[…] [c]onsiders best available scientific data […] [and] seeks to improve health outcomes to the greatest extent possible"—focusing on the importance of science-based medicine and equity-focused policies regardless of political or administrative pressures to the contrary[12].

Opinion 11.2.1 "Professionalism in Health Care Systems" notes that models for financing and organizing the delivery of health care services can "pose ethical challenges for physicians that could undermine the trust essential to patient-physician relationships" and acknowledges, "[f]ormularies, clinical practice guidelines, decision support tools […], and other mechanisms intended to influence decision making, may impinge on physicians' exercise of professional judgment and ability to advocate effectively for their patients, depending on how they are designed and implemented."[13] To support physicians in upholding their ethical obligations, the Opinion states that all such tools should be designed in keeping with science-based medical practices and implemented fairly. This focus on equity is also supported by Opinion 11.2.7 "Responsibilities to Promote Equitable Care".[14] Lastly, Opinion 11.2.2 "Conflicts of Interest in Patient Care" states, "[t]he primary objective of the medical profession is to render service to humanity; reward or financial gain is a subordinate consideration. Under no circumstances may physicians place their own financial interests above the welfare of their patients."[15] The Opinion concludes, "[w]here the economic interests of the hospital, health care organization, or other entity are in conflict with patient welfare, patient welfare takes priority."[15] These opinions emphasize the importance that physicians be allowed to practice science-based medicine grounded in medical ethics without undue pressure from outside influences, including political or administrative pressures that might in any way prevent physicians from upholding their professional and ethical commitments. Regardless of external influences, and often in spite of them, physicians have an ethical duty to support the patient-physician relationship to the best of their ability.

ETHICAL ISSUE

Current guidance in Opinion 1.1.1 "Patient-Physician Relationships" focuses heavily on legal considerations about when a relationship is established and has little purchase on the ethical

concerns raised by extensive changes to the practice of medicine that have recently occurred. Among these changes are the continuing development of technology (such as augmented intelligence), the use of team-based care, the rising number of employed physicians (as contrasted with those in private practice), interference in the patient-physician relationship by third parties (such as health care administrators, insurers or government), and the recognition that physicians have an obligation to advocate for changes to institutions, policies, and practices in order to improve patient care and promote health care justice.

A major change to the patient-physician relationship over the past few decades has been an increased recognition of the importance of patient autonomy. Ironically, however, this move away from paternalism towards patient autonomy in the setting of the patient-physician relationship has taken place while medicine has come to be dominated by large institutions, financial concerns such as cost-containment, changes in financing designed to influence patient and physician behavior, commercialization, an increasing reliance on markets, and other pressures that have had a de-professionalizing effect on physicians. These changes have led in turn to a loss of autonomy for both physicians and patients. Even as the discretionary space of physicians has shrunk, their responsibilities have expanded. Physicians are now called to engage in cultural competency and humility, trauma-informed approaches to care, and to recognize past harms and historical contexts of patient populations. They are called upon to be the mechanism by which medical inflation will be controlled. They are called upon to advocate not just only for their own individual patients within systems of care but to advocate for changes in the social systems that determine health care needs and distribute illness, injury, and disability unjustly.

Recognizing that each patient brings different experiences to the relationship is now seen as a crucial part of establishing trust within a patient-physician relationship. The question that arises, however, is how is that trust to be earned within systems that often appear untrustworthy and designed to frustrate the commitment of physicians to act for the good of their patients?

ETHICAL ANALYSIS

The patient-physician relationship is foundational for medical ethics. It is characterized by the nature of illness, the need for healing, and a commitment to help, culminating in a decision to take action directed toward healing and the alleviation of suffering caused by disease, injury, or disability. This relationship is inherently unequal. The patient is unavoidably in a position of vulnerability and dependency, while the physician holds the knowledge and the resources that the patient needs.[16] The sick, injured, and disabled therefore have little choice but to trust that their physicians will use the power of medicine for their good as individual patients. That trust is established by the physician's act of profession—the commitment, generally undertaken through an oath, to be worthy of patients' trust—and the patent's agreement to cooperative collaboration.

The heart of professionalism is thus the public commitment of physicians to use their medical knowledge, skills, and judgment for the good of their patients. Moreover, since patients are first and foremost persons, true healing can only take place when the uniqueness and personhood of patients are taken into account, incorporating their biological particularities, beliefs, relationships, emotions, values, and goals into medical decisions. This requires a mutually respectful, trusting collaboration aimed at serving the patient's good. For patients, this entails an obligation to seek care and be as candid as possible with their physicians.

All medical actions are oriented towards the ethical centrality of the patient-physician relationship. While the paradigmatic instance of this dynamic is serious illness, or injury, the care of patients with chronic conditions also requires a sustained, trusting relationship. Palliation, too, aims at the

relief of medical suffering and provides healing in a holistic sense even when cure is not possible. Prevention is also oriented towards the good of individual patients and requires trust that interventions are appropriate for that aim. Public health efforts provide the common resources necessary to promote healing and prevent illness, injury, and disability, and thus unite societal commitments to justice and prevention of harm with physicians' duties of beneficence, nonmaleficence, and respect for persons.

This understanding of the patient-physician relationship makes medicine an inherently moral enterprise, qualitatively different from the commercial transactions of providers and consumers. The patient-physician relationship itself is part of the healing process and not a commodity or product. Even economists recognize that the demand for health care is substantially inelastic and nonfungible, placing it outside the assumptions of normative market economics. Medical knowledge is not property that physicians own. It is a social good built up by the work of generations of physicians, scientists, and researchers and made possible by the generosity of generations of patients who have contributed to the advancement of medical progress (and who, it is acknowledged, have not always consented to such participation).

Medicine does not exist in a vacuum. Natural, historical, socioeconomic, and political circumstances always condition the patient-physician relationship. Physicians, for instance, do not always live up to the ideals of the profession. Structural social inequities result in unequal access to health care. While the patient-physician relationship itself is not a market commodity, markets provide many of the goods and services that physicians rely on to care for patients. Unfortunately, this also means that these goods and services are subject to the vicissitudes and inequities inherent to market systems, sexism, racism, and other unjust forms of discrimination.

Political decisions, for good or for ill, can also have a tremendous impact on care, affecting the distribution of physicians, the services they can provide for patients, the conditions under which physicians work, and the tenor of the patient-physician relationship. Therefore, if the good of the patient is the central moral focus of medicine, a commitment to justice will be required to ensure the integrity of the patient-physician relationship and to make the services of physicians available to all who stand in need of their care. In a pluralistic, liberal democracy, this requires, in turn, that professions be granted a relatively independent status outside other social institutions such as the market and the government. Too much encroachment by the market or the government into the legitimate authority of the medical profession ultimately undermines the central moral focus of medicine: the patient-physician relationship. Likewise, without the proper degree of self-regulation and respect for other social institutions, the medical profession itself can lose track of its own moral center. The good of the patient ought never to be made subservient to the political or financial ends of physicians, governments, or markets. Determining what the good of the patient is requires that physicians have the freedom and flexibility to adopt a patient-centered approach to care that allows for patients to feel heard and respected.

As the profession of medicine continues to change, there are concerns about how these changes impact patient-physician relationships and thus the relevance of the patient-physician relationship itself. However, despite the evolving landscape of the medical profession, the patient-physician relationship remains vital to the practice of medicine and to medical ethics. Regardless of changes to their roles that physicians face, clinical encounters will always be subject to the professional and ethical obligations that emerge from patient-physician relationships.

When we examine the patient-physician relationship, what we are really after is the source of the obligations that ground medical ethics. While medicine has always been practiced under non-ideal circumstances that can make it difficult to carry out these obligations to a maximal extent, we

recognize that current circumstances are making it more difficult than ever. Moreover, we recognize that a patient-physician relationship may arise in a variety of contexts, and that these may not always be geared towards benefiting the patient, the physician, or both. The goal of this report, however, is to outline the core aspects of ethical and just patient-physician relationships and articulate gaps in the current *Code* Opinion 1.1.1. in order to better support patients and physicians as the medical profession and health care ecosystems continue to evolve.

Trust and the Patient-Physician Relationship

The pressures of increasing de-professionalization and de-personalization in the healthcare environment have sometimes obscured or even seemed to denigrate the value of the patient-physician relationship. New ethical questions have arisen as systems of care have changed in ways that have made it more difficult for physicians to fulfil their duties that arise from a recognition that this relationship is central to the meaning and value of the profession. While the patient-physician relationship has responded and evolved in light of these challenges and in the face of other technological, economic, and sociocultural changes, there can be no doubt that patients' trust in medicine has declined. Nonetheless, there is also a renewed interest in the relational aspect of the patient-physician relationship and new attempts to build the trust that sustains it.

Trust is in many ways the cornerstone of any interpersonal relationship. Social psychologists who study trust have noted that the development of dyadic trust is a process that involves commitment, cooperation, and the building of confidence in benevolent values, motives, goals, and intentions.[17] Trust—and distrust—may be enacted in the immediate but is also built over time. Interpersonal trust is also impacted by (and in turn impacts) social trust, as social trust influences the development of interpersonal trust which then also impacts trust in the institutions in which interpersonal interactions take place.[18]

To protect the patient-physician relationship, then, a central goal of the medical profession should be to foster trust in health care, which has been in sharp decline for the past half century.[19] One of the primary means to engender trust is through good communication. Research has shown that aspects of physician communication can impact patient outcomes (such as medication compliance) and patient satisfaction (which is associated with greater continuity of care), and that patient-centered approaches to care, which consider the patient's perspective on equal ground with the physician's clinical diagnosis, enhance communication and the patient-physician relationship.[20]

Fostering Trust to Support the Patient-Physician Relationship

Research on physician communication practices have found at least five broad communication categories including: information giving, information seeking (questioning), partnership building, rapport-building behaviors (both verbal and nonverbal behaviors that explicitly convey emotional content), and socioemotional behaviors.[21] How patients and physicians view these aspects of communication, and the patient-physician relationship in general, are not always the same, however. In one study comparing physician and patient evaluations of the relationship, researchers found that while physicians identified their technical expertise and knowledge as vital for establishing trust in the relationship, emphasizing the importance of competence, devotion, serviceability, and reliability, patients stressed the importance of interpersonal skills as more important, such as caring, appreciation, and empathy.[22] Recognizing this difference in perceptions is crucial for understanding how trust can be gained or lost, especially considering that researchers found trust to make the largest contribution to patient-physician perceived satisfaction.[22]

Patient satisfaction is strongly associated with positive physician communication behaviors. Because physicians' communication behaviors vary widely, however, there is significant room here for improving patient-physician relationships. One study found that only 33% of physicians were rated "excellent" on all four communication behaviors analyzed, while 12% were rated either "fair" or "poor" on all four behaviors.[23] Patient-physician communication is one of the strongest factors that impact patient satisfaction and is fundamental to facilitating shared responsibility and trust.[24]

Communication is not the only value that engenders and supports trust. Research has found that clinicians whose patients expressed trust in them worked in environments that placed an emphasis on quality, communication, clinical cohesion, and alignment of values between clinicians and organizational leaders.[25] Like communication, physician empathy has also been regarded as central to patient-centered care, and research has found that empathy correlates with patient satisfaction, adherence, outcomes, and enablement.[26] Other models of trust establish foundational factors that include competency, motive, and transparency.[19]

The Future of Patient-Physician Relationships

When considering the source of the ideal patient-physician relationship, its emergence is simultaneously contractual, dependent on virtues, and relational. All three of these conceptual models rely on trust, and trust in turn is supported by additional values. Interpersonal trust is reliant upon collaboration, respect, empathy, and reciprocity. Contractual trust is reliant upon competency, transparency, aligned motives, and continuity. These values in many ways become ideal virtues within health care that help create trust in the institution of medicine over time, which is crucial for initial clinical encounters as well as for individuals who lack capacity. Regardless of external influences, such as political or administrative pressures, physicians have a responsibility first and foremost to their patients and to supporting the patient-physician relationship. When these influences create conflicting priorities, physicians should ensure that their actions align with their professional and ethical obligations.

Physicians have an ethical duty to support the patient-physician relationship by upholding the virtues of the profession. This ethical duty is grounded in medical professionalism and the commitment to serve as healers. The relationship that patients and physicians enter into is sustained by trust—in both the profession as whole, as well as in both the patient and the physician who agree to participate in a cooperative and collaborative partnership. This trust gives rise to physicians' ethical responsibility to place patients' welfare above the physician's own self-interest. This partnership is unique in that it is inherently unequal in terms of vulnerability, yet equal in importance with respect to both individuals' contributions to the relationship; similarly, the relationship is not a commodity product, yet it involves interacting with market economics. The patient-physician relationship is contextual—biological, historical, socioeconomic, and political elements will always be relevant—but it is also fundamentally a moral activity.

Honavar writes, "[the p]atient–physician relationship is a complex psychosocial interplay of vulnerability, trust, and authority in a professional setting".[27] Currently, the *Code* primarily speaks to the importance of trust within the patient-physician relationship without acknowledging that the reason trust is crucial is because of the unequal vulnerabilities and authorities at play. The power dynamics of every patient-physician relationship will be different, of course, but it is crucial that the *Code* address such concepts as patient vulnerability, the importance of respect, communication, and competency in establishing trust. Ultimately, Opinion 1.1.1 must move beyond the current language that focuses on when a patient-physician relationship begins in order to more fully address how to ethically and justly sustain the relationship. Furthermore, knowing that the practice of medicine will continue to change and that as a result, so too will patient-physician relationships,

the *Code* needs to clearly acknowledge that patient-physician relationships are inherently dynamic, contextual, and will continue to evolve.

RECOMMENDATION

Your Council on Ethical and Judicial Affairs recommends that Opinion 1.1.1, "Patient Physician Relationships" be amended by addition and deletion and the remainder of this report be filed.

The practice of medicine, and its embodiment in the clinical encounter between a patient and a physician, is fundamentally a moral activity that arises from the imperative to care for patients and to alleviate suffering. ~~The relationship between a patient and a physician is based on trust, which gives rise to~~ The relationship that emerges between a patient and a physician must be based on trust. The physician's obligation to be trustworthy entails additional ethical duties such as a commitment to act for the good of patients; to uphold respect for patients as persons; to develop good communication skills; and to be professionally competent. This trust is fostered by physicians' ethical responsibilit~~y~~ies to place patients' welfare above the physician's own self-interest or obligations to others, to use sound medical judgment on patients' behalf, and to advocate for their patients' welfare. When external influences negatively impact this trust, or the patient-physician relationship directly, physicians individually and collectively should advocate for changes to ameliorate the situation and promote a more hospitable environment in which patient-physician relationships may flourish.

A patient-physician relationship ~~exists~~ commences when a physician begins to serve a patient's medical needs. ~~Generally, the relationship is entered into by mutual consent between physician and patient (or surrogate). However, in certain circumstances a limited patient-physician relationship may be created without the patient's (or surrogate's) explicit agreement. Such circumstances include:~~ The contexts that may lead to a patient-physician relationship vary: they generally occur as a response to a request by a patient or a patient's surrogate, but can also include certain contractual, legally mandated, or emergency settings without the explicit request or consent of the patient.

While the patient-physician relationship may involve one patient and one physician in today's complex health care system, such relationships often involve multiple members of a care team, patient family members and surrogates. The core values of the patient-physician relationship, however, remain unchanged. How these values are implemented will depend on many factors, including the setting, the needs of the patient, the duration of the relationship, and the training, expertise, and experience of the physician, and will necessarily reflect the myriad ways that patients and physicians interact. While every patient-physician relationship will be different and will change over time, the fundamental importance of establishing and sustaining trust through respect for persons, good communication, and professional competency will always be crucial at every layer, node, and time of the relationship. It is the duty of physicians, therefore, to uphold these values and support patients and the primacy of the patient-physician relationship to the best of their ability in all practice settings and at all times.

~~(a) When a physician provides emergency care or provides care at the request of the patient's treating physician. In these circumstances, the patient's (or surrogate's) agreement to the relationship is implicit.~~

~~(b) When a physician provides medically appropriate care for a prisoner under court order, in keeping with ethics guidance on court-initiated treatment.~~

(c) ~~When a physician examines a patient in the context of an independent medical examination, in keeping with ethics guidance. In such situations, a limited patient-physician relationship exists.~~

(Modify HOD/CEJA Policy)

Fiscal Note: Minimal

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CEJA Report 3-A-16 Modernized Code of Medical Ethics

Opinion 1.1.1 Patient-Physician Relationships

The practice of medicine, and its embodiment in the clinical encounter between a patient and a physician, is fundamentally a moral activity that arises from the imperative to care for patients and to alleviate suffering. The relationship between a patient and a physician is based on trust, which gives rise to physicians' ethical responsibility to place patients' welfare above the physician's own self-interest or obligations to others, to use sound medical judgment on patients' behalf, and to advocate for their patients' welfare.

A patient-physician relationship exists when a physician serves a patient's medical needs. Generally, the relationship is entered into by mutual consent between physician and patient (or surrogate).

However, in certain circumstances a limited patient-physician relationship may be created without the patient's (or surrogate's) explicit agreement. Such circumstances include:

(a) When a physician provides emergency care or provides care at the request of the patient's treating physician. In these circumstances, the patient's (or surrogate's) agreement to the relationship is implicit.

(b) When a physician provides medically appropriate care for a prisoner under court order, in keeping with ethics guidance on court-initiated treatment.

(c) When a physician examines a patient in the context of an independent medical examination, in keeping with ethics guidance. In such situations, a limited patient-physician relationship exists. [new guidance cross-references guidance in Opinion 1.2.6]

AMA Principles of Medical Ethics: I,II,IV,VIII

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS

CEJA Report 1-A-01

Subject: The Patient-Physician Relationship

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

Introduction

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

The current *Code*'s focus on the relationship between physician and patient is exemplified by the *Fundamental Elements of the Patient-Physician Relationship* issued in 1990.[4] In particular, physicians are to foster this partnership by providing information and allowing for autonomous decision-making, acting respectfully and in a timely manner, preserving confidentiality, ensuring continuity of care, and facilitating access to care. Despite this list of features of the relationship patients can expect from physicians and which physicians must strive to fulfill, the very nature of the patient-physician relationship remains unexamined.

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

Conceptualizing the patient-physician relationship

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

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

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

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

Ethical obligations of physicians

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

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

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

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

Conflicts of interest

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

Conflicts between physicians' and patients' interests

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

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

Conflicts between individual patients and patient populations

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

Conclusion

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

Recommendations

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

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

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

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

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

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