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.

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

Background report(s):

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

CEJA Report 1-A-01, The Patient-Physician Relationship

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

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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

Presented by: Herbert Rakatansky, MD, Chair

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

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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