PRINCIPLES OF MEDICAL ETHICS: THE PROPOSED REVISION OF 2001

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EARLY HISTORY OF THE PRINCIPLES OF MEDICAL ETHICS

For nearly two thousand years following the Hippocratic era, expressions of medical ethics took the form of oaths and prayers, exemplified by the Hippocratic Oath and the Prayer of Maimonides. The first formal code of ethics did not appear until the nineteenth century.

In 1792, an administrative disagreement among staff members led to the closing of the fever ward of the Manchester Infirmary during an epidemic.1 Thomas Percival was asked to head a committee to look into the incident and to draft guidelines to assure that internal disputes would never again close the wards. A set of rules was developed, but Percival perceived that the nature of medical practice was changing and required a much more extensive and specific set of professional guidelines than had been available. He spent the next ten years developing such guidelines, and published them in 1803: Medical Ethics: A Code of Ethics and Institutes Adopted to the Professions of Physic and Surgery.

Percival’s code broke new ground in many ways. For example, he used the term “attending physician” for the first time and coined the terms “medical ethics” to denote a structure of ethics for individual physicians and “professional ethics” to denote an ethic for the profession as a whole. Percival’s code was little noted in Europe, but was widely used in the United States. It was used here, perhaps for the first time, in 1808 when the Boston Medical Society adopted parts of Percival’s work to describe procedures for self-regulation. Many other county and state medical societies followed this example over the next several decades.2

In 1847, the American Medical Association came into existence, intending that it would be a model of professional self-regulation. One of its first acts was to create the “Code of Ethics” that was taken nearly intact from Percival’s. Substantial revision of the AMA’s code was undertaken in 1903, when it was renamed “Principles of Medical Ethics,” and again in 1912. Only minor changes were made over the next several decades.

In the mid-1950s, the code was not only revised, but was restructured. Before this revision, it was lengthy, comprising 47 sections and thousands of words. The essence of the code was abstracted into a pithy set of ten principles, easily fitting onto one page; this brief set was given the name, “Principles of Medical Ethics.” Discussions and interpretations of the principles were organized into a series of “Opinions,” classified according to subject matter. These were published together in 1957 under the title, “Opinions and Reports of the Judicial Council.” Two sections were added later, “Fundamental Elements of the Patient/Physician Relationship” and “Obligations of Patients.” Today, the “Code of Medical Ethics” comprises these four elements.3

After 1957, the Principles were revised once, in 1980. This revision responded to a complaint filed by the Federal Trade Commission in late 1975, charging that the Code’s prohibition of advertising and solicitation of patients constituted restraint of trade. A series of negotiations, lawsuits, and court decisions ensued.4 In 1978, a special committee of the House of Delegates was appointed to review the Code of Medical Ethics. A new set of Principles was adopted by the AMA House of Delegates in 1980, reducing...
the Principles from ten in number to seven. At the direction of the FTC, the new Principles omitted entirely a sentence from the 1957 version (Section 5), which stated: “[The physician] should not solicit patients”. The Code remained the subject of negotiations and court challenges involving the AMA and the FTC; these did not conclude until 1988, with modification of the Opinions relevant to advertising.

RECENT EVENTS AFFECTING THE PRINCIPLES
In the two decades since the 1980 revision of the Principles, the health care industry has undergone a sea change. Health care costs rose much faster than the consumer price index, creating a cost crisis in health care. In response, the managed care industry grew rapidly, developing many new methods of cost control, including financial and other incentives for physicians to limit the care provided to patients. The burden of paperwork imposed by new governmental regulations added to the burdens imposed by managed care and insurance companies. Cost control measures by both government and industry resulted in sharply reduced incomes for many groups of physicians, at the same time as they faced increasing burdens of documentation and compliance. These and other important changes in the health care environment led to a series of resolutions in the AMA House of Delegates, beginning in 1997, recommending a new revision of the Principles.

The Council on Ethical and Judicial Affairs (CEJA) of the AMA undertook the challenge of revising the Principles. It solicited input from AMA membership at two open forums, in June, 1998, and, again, in June, 1999. Comments and suggestions were solicited from a variety of other organizations, including the Federation of Medicine, state medical societies and national specialty groups, as well as interested individuals. Through this dialogue, CEJA developed a revision of the 1980 Principles, which was presented to the House of Delegates at its Interim Meeting in December, 2000. A few mostly editorial changes were made at that meeting, and the final vote to amend the Principles will take place at the Annual Meeting in June, 2001.

THE PROPOSED REVISION
By their nature, well-grounded principles do not change over time. New circumstances, however, may require changing the way a principle is stated to emphasize a particular idea or to recognize explicitly a notion that was previously implicit. In the 2001 revision, therefore, most of the 1980 language has remained untouched. A few changes in emphasis have been made, and two new principles have been added, bringing the total from seven to nine. The 1980 and the 2001 versions of the Principles can be viewed side by side on page 75.

Perhaps the most important change is heightened visibility of the idea that the physician’s first obligation is to his patients. In formative discussions of the revision, this was the most frequently recommended and vigorously supported change, perhaps because of the many influences in recent years that have tended to displace physicians’ loyalty from patients to others. Although the notion that loyalty to the patient is the first among the many responsibilities and obligations of physicians, it has not been explicitly stated in previous versions of the Principles. In the proposed version, the idea is reflected in two places. To the Preamble has been added the phrase, “...a physician must recognize responsibility to patients first and foremost...” Moreover, a new principle (VIII) reiterates the same point: “A physician shall, while caring for a patient, regard responsibility to the patient as paramount.” This will be further discussed below.

In principle I, the term “medical service” has been changed to “medical care” because care has broader connotations than service, and more accurately represents what physicians do for patients. Moreover, the two words, “and rights,” have been added at the end, to recognize recent emphasis on patients’ rights.

Principle II contains two changes. The first is addition of the clause “A physician shall uphold the standards of professionalism.” A variety of policies, regulations, and proffered contracts have seemed to be intended to entice some physicians to practice outside or below what are considered to be standards of professionalism. The first
addition makes it clear that upholding those standards is ethically required. The revised principle II also adds the requirement that a physician "be honest in all professional interactions." Third parties, particularly managed care organizations, have, in many cases, placed sharp limits on services available to their clients, making it more difficult for patients to obtain some kinds of needed health care. Many mechanisms are available to help physicians advocate for all needed care for their patients, such as appeal procedures. The one unacceptable mechanism of advocacy is to deceive insurance companies by misrepresenting patient information (Opinion 9.132). While earlier versions of the Principles state that "A physician shall deal honestly with patients and colleagues," the proposed 2001 version requires honesty "in all professional interactions," thus including third parties in the ethical obligation to be honest.

To principle V, a new clause has been added: "A physician shall . . . maintain a commitment to medical education . . ." This addition recognizes the central importance of the rapidly growing volume of new knowledge in medical care and, in addition, the importance of its transmission to others by practicing physicians. It makes explicit the ethical stature of the traditional dedication of physicians to life long learning for themselves, and of transmitting their knowledge and wisdom to colleagues, patients, medical students, and other trainees in medicine.

To the end of principle VII has been added the phrase, "... and the betterment of public health." The responsibility to participate in activities contributing to the improvement of the community is a general responsibility that covers activities within and outside of health care. The addition of public health emphasizes the medical component of community involvement.

The remaining two principles are entirely new. Principle VIII was described at the beginning of this section. Its idea is so important that it bears repetition here. Primary responsibility to the patient has been understood as the integrating thread running through all of medical ethics since long before Percival's Code. Yet, the AMA's Principles has never expressly stated this central notion. In the revised 2001 version, it becomes explicit both in the preamble and in principle VIII.

In regarding the interests of patients as paramount, physicians incur an obligation to support access to medical care for everyone. This does not mean that a physician must treat every patient seeking care, nor does it refer to a specific form of health care financing, either market based or government imposed. It means that each physician has an obligation to contribute time, energy, or other resources to reduce the likelihood that anyone in need of medical care will not be cared for, in one way or another. For some, this may mean treating indigent patients in their private offices. For others it may take the form of contributing a few hours a week to a public clinic. For still others it may take the form of devoting time and money to political causes that they believe promise the best solutions to assuring access for most people. These causes may promote tax reform and privatization of the health care industry, or, conversely, may promote a single payer system. Every physician will find a different way to realize this particular ethical obligation.

These changes in the Principles of Medical Ethics will not become permanent until the House of Delegates votes in June. Please communicate your thoughts and comments to your county or state medical society officials, as noted in the accompanying box.

REFERENCES


4. Hirsh BD. Antitrust and Medical Ethics. JAMA. 1983;250(20):2759-60
PRINCIPLES
MEDICAL ETHICS

The professionalism embodied in the American Medical Association’s Principles of Medical Ethics is of critical importance to maintaining the integrity of medicine as a profession. This article briefly describes the historical background of the development of the Principles and provides an explanation of the changes that have been suggested in the latest revision. The article is meant to bring these proposed changes to the attention of the physicians of South Carolina. We encourage you to communicate your thoughts about the changes, either approving or disapproving, to your county medical society’s trustee on the South Carolina Medical Association Board of Trustees, to any officer of the SCMA, or to the author of this article. We wish to provide an opportunity for the voice of every interested physician in South Carolina to be heard in this important matter.

Principles of Medical Ethics (1980)

PREAMBLE. The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsibility not only to patients, but also to society, to other health professionals, and to self. The following Principles adopted by the American Medical Association are not laws, but standards of conduct which define the essentials of honorable behavior for the physician.

I. A physician shall be dedicated to providing competent medical service with compassion and respect for human dignity.

II. A physician shall deal honestly with patients and colleagues, and strive to expose those physicians deficient in character or competence, or who engage in fraud or deception.

III. A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient.

IV. A physician shall respect the rights of patients, colleagues, and of other health professionals, and shall safeguard patient confidences within the constraints of the law.

V. A physician shall continue to study, apply and advance scientific knowledge, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.

VI. A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical services.

VII. A physician shall recognize a responsibility to participate in activities contributing to an improved community.

Principles of Medical Ethics (2001)

PREAMBLE. The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsibility to patients first and foremost, as well as to society, to other health professionals, and to self. The following Principles adopted by the American Medical Association are not laws, but standards of conduct which define the essentials of honorable behavior for the physician.

I. A physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights.

II. A physician shall uphold the standards of professionalism, be honest in all professional interactions, and strive to report physicians deficient in character or competence, or engaging in fraud or deception, to appropriate entities.

III. A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient.

IV. A physician shall respect the rights of patients, colleagues, and other health professionals, and shall safeguard patient confidences and privacy within the constraints of the law.

V. A physician shall continue to study, apply, and advance scientific knowledge, maintain a commitment to medical education, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.

VI. A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical care.

VII. A physician shall recognize a responsibility to participate in activities contributing to the improvement of the community and the betterment of public health.

VIII. A physician shall, while caring for a patient, regard responsibility to the patient as paramount.

IX. A physician shall support access to medical care for all people.

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