

CHAPTER 9: OPINIONS ON PROFESSIONAL SELF-REGULATION

The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.

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9.1.1 Romantic or Sexual Relationships with Patients

Romantic or sexual interactions between physicians and patients that occur concurrently with the patient-physician relationship are unethical. Such interactions detract from the goals of the patient-physician relationship and may exploit the vulnerability of the patient, compromise the physician's ability to make objective judgments about the patient's health care, and ultimately be detrimental to the patient's well-being.

A physician must terminate the patient-physician relationship before initiating a dating, romantic, or sexual relationship with a patient.

Likewise, sexual or romantic relationships between a physician and a former patient may be unduly influenced by the previous physician-patient relationship. Sexual or romantic relationships with former patients are unethical if the physician uses or exploits trust, knowledge, emotions, or influence derived from the previous professional relationship, or if a romantic relationship would otherwise foreseeably harm the individual.

In keeping with a physician's ethical obligations to avoid inappropriate behavior, a physician who has reason to believe that nonsexual, nonclinical contact with a patient may be perceived as or may lead to romantic or sexual contact should avoid such contact.

AMA Principles of Medical Ethics: I,II,IV

9.1.2 Romantic or Sexual Relationships with Key Third Parties

Patients are often accompanied by third parties who play an integral role in the patient-physician relationship, including, but not limited to, spouses or partners, parents, guardians, or surrogates. Sexual or romantic interactions between physicians and third parties such as these may detract from the goals of the patient-physician relationship, exploit the vulnerability of the third party, compromise the physician's ability to make objective judgments about the patient's health care, and ultimately be detrimental to the patient's well-being.

Third parties may be deeply involved in the clinical encounter and in medical decision making. The physician interacts and communicates with these individuals and often is in a position to offer them information, advice, and emotional support. The more deeply involved the individual is in the clinical encounter and in medical decision making, the stronger the argument against sexual or romantic contact between the physician and a key third party. Physicians should avoid sexual or romantic relations with any individual whose decisions directly affect the health and welfare of the patient.

For these reasons, physicians should refrain from sexual or romantic interactions with key third parties when the interaction would exploit trust, knowledge, influence, or emotions derived from a professional relationship with the third party or could compromise the patient's care.

Before initiating a relationship with a key third party, physicians should take into account:

- (a) The nature of the patient’s medical problem and the likely effect on patient care.
- (b) The length of the professional relationship.
- (c) The degree of the third party’s emotional dependence on the physician.
- (d) The importance of the clinical encounter to the third party and the patient.
- (e) Whether the patient-physician relationship can be terminated in keeping with ethics guidance and what implications doing so would have for patient.

AMA Principles of Medical Ethics: I,II

9.1.3 Sexual Harassment in the Practice of Medicine

Sexual harassment can be defined as unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature.

Sexual harassment in the practice of medicine is unethical. Sexual harassment exploits inequalities in status and power, abuses the rights and trust of those who are subjected to such conduct; interferes with an individual’s work performance, and may influence or be perceived as influencing professional advancement in a manner unrelated to clinical or academic performance harm professional working relationships, and create an intimidating or hostile work environment; and is likely to jeopardize patient care. Sexual relationships between medical supervisors and trainees are not acceptable, even if consensual. The supervisory role should be eliminated if the parties wish to pursue their relationship.

Physicians should promote and adhere to strict sexual harassment policies in medical workplaces. Physicians who participate in grievance committees should be broadly representative with respect to gender identity or sexual orientation, profession, and employment status, have the power to enforce harassment policies, and be accessible to the persons they are meant to serve.

AMA Principles of Medical Ethics: II,IV,VII

9.2.1 Medical Student Involvement in Patient Care

Having contact with patients is essential for training medical students, and both patients and the public benefit from the integrated care that is provided by health care teams that include medical students. However, the obligation to develop the next generation of physicians must be balanced against patients’ freedom to choose from whom they receive treatment.

All physicians share an obligation to ensure that patients are aware that medical students may participate in their care and have the opportunity to decline care from students. Attending physicians may be best suited to fulfill this obligation. Before involving medical students in a patient’s care, physicians should:

- (a) Convey to the patient the benefits of having medical students participate in their care.
- (b) Inform the patients about the identity and training status of individuals involved in care. Students, their supervisors, and all health care professionals should avoid confusing terms and properly identify themselves to patients.

- (c) Inform the patient that trainees will participate before a procedure is undertaken when the patient will be temporarily incapacitated.
- (d) Discuss student involvement in care with the patient's surrogate when the patient lacks decision-making capacity.
- (e) Confirm that the patient is willing to permit medical students to participate in care.

AMA Principles of Medical Ethics: V, VII

9.2.2 Resident & Fellow Physicians' Involvement in Patient Care

Residents and fellows have dual roles as trainees and caregivers. Residents and fellows share responsibility with physicians involved in their training to facilitate educational and patient care goals.

Residents and fellows are physicians first and foremost and should always regard the interests of patients as paramount. When they are involved in patient care, residents and fellows should:

- (a) Interact honestly with patients, including clearly identifying themselves as members of a team that is supervised by the attending physician and clarifying the role they will play in patient care. They should notify the attending physician if a patient refuses care from a resident or fellow.
- (b) Participate fully in established mechanisms in their training programs and hospital systems for reporting and analyzing errors. They should cooperate with attending physicians in communicating errors to patients.
- (c) Monitor their own health and level of alertness so that these factors do not compromise their ability to care for patients safely. Residents and fellows should recognize that providing patient care beyond time permitted by their programs (for example, "moonlighting" or other activities that interfere with adequate rest during off hours) might be harmful to themselves and patients.

Physicians involved in training residents and fellows should:

- (d) Take steps to help ensure that training programs are structured to be conducive to the learning process as well as to promote the patient's welfare and dignity.
- (e) Address patient refusal of care from a resident or fellow. If after discussion, a patient does not want to participate in training, the physician may exclude residents or fellows from the patient's care. If appropriate, the physician may transfer the patient's care to another physician or nonteaching service or another health care facility.
- (f) Provide residents and fellows with appropriate faculty supervision and availability of faculty consultants, and with graduated responsibility relative to level of training and expertise.

- (g) Observe pertinent regulations and seek consultation with appropriate institutional resources, such as an ethics committee, to resolve educational or patient care conflicts that arise in the course of training. All parties involved in such conflicts must continue to regard patient welfare as the first priority. Conflict resolution should not be punitive, but should aim at assisting residents and fellows to complete their training successfully.

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

9.2.3 Performing Procedures on the Newly Deceased

Medical training sometimes involves practicing procedures on newly deceased patients, in particular, critical medical skills for which adequate educational alternatives are not available. Such training must balance protecting the interests of newly deceased patients, their families, society, and the profession with the need to educate health care providers.

Physicians should work to develop clear institutional policies for performing procedures on newly deceased patients for training purposes. Before medical trainees practice any procedure on a newly deceased patient, the supervising physician has an ethical responsibility to ensure that:

- (a) The interests of all parties are respected and the risks and benefits of permitting the procedure have been carefully considered, including:
 - (i) the rights of deceased patients and their families;
 - (ii) benefits to trainees and society;
 - (iii) risks to trainees, staff, the institution, and the profession.
- (b) The procedure is carried out:
 - (i) as part of an appropriately structured training sequence;
 - (ii) in a manner and an environment that is respectful of the values of all involved parties.
- (c) Permitting trainees to perform the procedure is in keeping with the previously expressed preferences of the deceased individual regarding handling of the body or procedures performed after death.
- (d) Permission for a trainee to perform the procedure is obtained from the decedent's family if the individual's preferences are not known. Procedures should never be performed for training purposes if the decedent's wishes are not known and permission is not available from an appropriate surrogate.
- (e) The procedure is entered in the medical record.

AMA Principles of Medical Ethics: I,V

9.2.4 Disputes between Medical Supervisors & Trainees

The relationship between medical students, resident physicians or fellows, and their supervisors is a major determinant of the quality of medical education. When conflicts arise, it is essential to ensure that disputes are resolved fairly.

Retaliatory or punitive actions against those who raise complaints are unethical and are a legitimate cause for filing a grievance with the appropriate institutional committee.

Physicians who are involved in training or supervising medical students, residents, and fellows should ensure that institutional policies and procedures are in place to:

- (a) Protect complainants' confidentiality whenever possible, so long as protecting confidentiality does not hinder the subject's ability to respond to the complaint.
- (b) Carefully monitor employment and evaluation files to prevent possible tampering.
- (c) Permit resident physicians and fellows to access to their employment files and copy the contents, within the provisions of applicable law.
- (d) Support medical students, residents, and fellows in fulfilling their responsibility to:
 - (i) withdraw from care ordered by a supervisor when the trainee believes the order reflects serious errors in clinical or ethical judgment, or physician impairment, that could pose a risk of imminent harm to the patient or others, provided withdrawing does not itself threaten the patient's immediate welfare;
 - (ii) communicate concerns to the physician issuing the orders and, if necessary, to the persons or institutional programs responsible for mediating such disputes, which may involve third parties.

AMA Principles of Medical Ethics: II,III,VII

9.2.5 Medical Students Practicing Clinical Skills on Fellow Students

Medical students often learn basic clinical skills by practicing on classmates, patients, or trained instructors. Unlike patients in the clinical setting, students who volunteer to act as "patients" are not seeking to benefit medically from the procedures being performed on them. Their goal is to benefit from educational instruction, yet their right to make decisions about their own bodies remains.

To protect medical students' privacy, autonomy, and sense of propriety in the context of practicing clinical skills on fellow students, instructors should:

- (a) Explain to students how the clinical skills will be performed, making certain that students are not placed in situations that violate their privacy or sense of propriety.
- (b) Discuss the confidentiality, consequences, and appropriate management of a diagnostic finding.

- (c) Ask students to specifically consent to clinical skills being performed by fellow students. The stringency of standards for ensuring explicit, noncoerced informed consent increases as the invasiveness and intimacy of the procedure increase.
- (d) Allow students the choice of whether to participate prior to entering the classroom.
- (e) Never require that students provide a reason for their unwillingness to participate.
- (f) Never penalize students for refusing to participate. Instructors must refrain from evaluating students' overall performance based on their willingness to volunteer as "patients."

AMA Principles of Medical Ethics: IV,V

9.2.6 Continuing Medical Education

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 certified 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 ethics guidance and applicable professional standards.
- (c) Claim only the credit commensurate with the extent of participation in the CME activity.
- (d) Decline any subsidy offered by a commercial entity other than the physician's employer to compensate the physician for time spent or expenses of participating in a CME activity.

AMA Principles of Medical Ethics: I,V

9.2.7 Financial Relationships with Industry in Continuing Medical Education

In an environment of rapidly changing information and emerging technology, physicians must maintain the knowledge, skills, and values central to a healing profession. They must protect the independence and commitment to fidelity and service that define the medical profession.

Financial or in-kind support from pharmaceutical, biotechnology or medical device companies that have a direct interest in physicians' recommendations creates conditions in which external interests could influence the availability and/or content of continuing medical education (CME). Financial relationships between such sources and individual physicians who organize CME, teach in CME, or have other roles in continuing professional education can carry similar potential to influence CME in undesired ways.

CME that is independent of funding or in-kind support from sources that have financial interests in physicians' recommendations promotes confidence in the independence and integrity of professional education, as does CME in which organizers, teachers, and others involved in educating physicians do not have financial relationships with industry that could influence their participation. When possible, CME

should be provided without such support or the participation of individuals who have financial interests in the educational subject matter.

In some circumstances, support from industry or participation by individuals who have financial interests in the subject matter may be needed to enable access to appropriate, high-quality CME. In these circumstances, physician-learners should be confident that vigorous efforts will be made to maintain the independence and integrity of educational activities.

Individually and collectively physicians must ensure that the profession independently defines the goals of physician education, determines educational needs, and sets its own priorities for CME. Physicians who attend CME activities should expect that, in addition to complying with all applicable professional standards for accreditation and certification, their colleagues who organize, teach, or have other roles in CME will:

- (a) Be transparent about financial relationships that could potentially influence educational activities.
- (b) Provide the information physician-learners need to make critical judgments about an educational activity, including:
 - (i) the source(s) and nature of commercial support for the activity; and/or
 - (ii) the source(s) and nature of any individual financial relationships with industry related to the subject matter of the activity; and
 - (iii) what steps have been taken to mitigate the potential influence of financial relationships.
- (c) Protect the independence of educational activities by:
 - (i) ensuring independent, prospective assessment of educational needs and priorities;
 - (ii) adhering to a transparent process for prospectively determining when industry support is needed;
 - (iii) giving preference in selecting faculty or content developers to similarly qualified experts who do not have financial interests in the educational subject matter;
 - (iv) ensuring a transparent process for making decisions about participation by physicians who may have a financial interest in the educational subject matter;
 - (v) permitting individuals who have a substantial financial interest in the educational subject matter to participate in CME only when their participation is central to the success of the educational activity; the activity meets a demonstrated need in the professional community; and the source, nature, and magnitude of the individual's specific financial interest is disclosed; and
 - (vi) taking steps to mitigate potential influence commensurate with the nature of the financial interest(s) at issue, such as prospective peer review.

AMA Principles of Medical Ethics: I,V

9.3.1 Physician Health & Wellness

When physician health or wellness is compromised, so may the safety and effectiveness of the medical care provided. To preserve the quality of their performance, physicians have a responsibility to maintain their health and wellness, broadly construed as preventing or treating acute or chronic diseases, including mental illness, disabilities, and occupational stress.

To fulfill this responsibility individually, physicians should:

- (a) Maintain their own health and wellness by:
 - (i) following healthy lifestyle habits;
 - (ii) ensuring that they have a personal physician whose objectivity is not compromised.
- (b) Take appropriate action when their health or wellness is compromised, including:
 - (i) engaging in honest assessment of their ability to continue practicing safely;
 - (ii) taking measures to mitigate the problem;
 - (iii) taking appropriate measures to protect patients, including measures to minimize the risk of transmitting infectious disease commensurate with the seriousness of the disease;
 - (iv) seeking appropriate help as needed, including help in addressing substance abuse. Physicians should not practice if their ability to do so safely is impaired by use of a controlled substance, alcohol, other chemical agent or a health condition.

Collectively, physicians have an obligation to ensure that colleagues are able to provide safe and effective care, which includes promoting health and wellness among physicians.

AMA Principles of Medical Ethics: I,II,IV

9.3.2 Physician Responsibilities to Impaired Colleagues

Physical or mental health conditions that interfere with a physician's ability to engage safely in professional activities can put patients at risk, compromise professional relationships, and undermine trust in medicine. While protecting patients' well-being must always be the primary consideration, physicians who are impaired are deserving of thoughtful, compassionate care.

To protect patient interests and ensure that their colleagues receive appropriate care and assistance, individually physicians have an ethical obligation to:

- (a) Intervene in a timely manner to ensure that impaired colleagues cease practicing and receive appropriate assistance from a physician health program.
- (b) Report impaired colleagues in keeping with ethics guidance and applicable law.
- (c) Assist recovered colleagues when they resume patient care.

Collectively, physicians have an obligation to ensure that their colleagues are able to provide safe and effective care. This obligation is discharged by:

- (d) Promoting health and wellness among physicians.
- (e) Establishing mechanisms to assure that impaired physicians promptly cease practice.
- (f) Supporting peers in identifying physicians in need of help.
- (g) Establishing or supporting physician health programs that provide a supportive environment to maintain and restore health and wellness.

AMA Principles of Medical Ethics: II

9.4.1 Peer Review & Due Process

Physicians have mutual obligations to hold one another to the ethical standards of their profession. Peer review, by the ethics committees of medical societies, hospital credentials and utilization committees, or other bodies, has long been established by organized medicine to scrutinize professional conduct. Peer review is recognized and accepted as a means of promoting professionalism and maintaining trust. The peer review process is intended to balance physicians' right to exercise medical judgment freely with the obligation to do so wisely and temperately.

Fairness is essential in all disciplinary or other hearings where the reputation, professional status, or livelihood of the physician or medical student may be adversely affected.

Individually, physicians and medical students who are involved in reviewing the conduct of fellow professionals, medical students, residents or fellows should:

- (a) Always adhere to principles of a fair and objective hearing, including:
 - (i) a listing of specific charges,
 - (ii) adequate notice of the right of a hearing,
 - (iii) the opportunity to be present and to rebut the evidence, and
 - (iv) the opportunity to present a defense.
- (b) Ensure that the reviewing body includes a significant number of persons at a similar level of training.
- (c) Disclose relevant conflicts of interest and, when appropriate, recuse themselves from a hearing.

Collectively, through the medical societies and institutions with which they are affiliated, physicians should ensure that such bodies provide procedural safeguards for due process in their constitutions and bylaws or policies.

AMA Principles of Medical Ethics: II,III,VII

9.4.2 Reporting Incompetent or Unethical Behaviors by Colleagues

Medicine has a long tradition of self-regulation, based on physicians' enduring commitment to safeguard the welfare of patients and the trust of the public. The obligation to report incompetent or unethical conduct that may put patients at risk is recognized in both the ethical standards of the profession and in law and physicians should be able to report such conduct without fear or loss of favor.

Reporting a colleague who is incompetent or who engages in unethical behavior is intended not only to protect patients, but also to help ensure that colleagues receive appropriate assistance from a physician health program or other service to be able to practice safely and ethically. Physicians must not submit false or malicious reports.

Physicians who become aware of or strongly suspect that conduct threatens patient welfare or otherwise appears to violate ethical or legal standards should:

- (a) Report the conduct to appropriate clinical authorities in the first instance so that the possible impact on patient welfare can be assessed and remedial action taken. This should include notifying the peer review body of the hospital, or the local or state medical society when the physician of concern does not have hospital privileges.
- (b) Report directly to the state licensing board when the conduct in question poses an immediate threat to the health and safety of patients or violates state licensing provisions.
- (c) Report to a higher authority if the conduct continues unchanged despite initial reporting.
- (d) Protect the privacy of any patients who may be involved to the greatest extent possible, consistent with due process.
- (e) Report the suspected violation to appropriate authorities.

Physicians who receive reports of alleged incompetent or unethical conduct should:

- (f) Evaluate the reported information critically and objectively.
- (g) Hold the matter in confidence until it is resolved.
- (h) Ensure that identified deficiencies are remedied or reported to other appropriate authorities for action.
- (i) Notify the reporting physician when appropriate action has been taken, except in cases of anonymous reporting.

AMA Principles of Medical Ethics: II

9.4.3 Discipline & Medicine

Incompetence, corruption, dishonest, or unethical conduct on the part of members of the medical profession is reprehensible. In addition to posing a real or potential threat to patients, such conduct undermines the public's confidence in the profession. The obligation to address misconduct falls on both individual physicians and on the profession as a whole.

The goal of disciplinary review is both to protect patients and to help ensure that colleagues receive appropriate assistance from a physician health program or other service to enable them to practice safely and ethically. Disciplinary review must not be undertaken falsely or maliciously.

Individually, physicians should report colleagues whose behavior is incompetent or unethical in keeping with ethics guidance.

Collectively, medical societies have a civic and professional obligation to:

- (a) Report to the appropriate governmental body or state board of medical examiners credible evidence that may come to their attention involving the alleged criminal conduct of any physician relating to the practice of medicine.
- (b) Initiate disciplinary action whenever a physician is alleged to have engaged in misconduct whenever there is credible evidence tending to establish unethical conduct, regardless of the outcome of any civil or criminal proceedings relating to the alleged misconduct.
- (c) Impose a penalty, up to and including expulsion from membership, on a physician who violates ethical standards.

AMA Principles of Medical Ethics: II,III,VII

9.4.4 Physicians with Disruptive Behavior

The importance of respect among all health professionals as a means of ensuring good patient care is foundational to ethics. Physicians have a responsibility to address situations in which individual physicians behave disruptively, that is, speak or act in ways that may negatively affect patient care, including conduct that interferes with the individual's ability to work with other members of the health care team, or for others to work with the physician.

Disruptive behavior is different from criticism offered in good faith with the aim of improving patient care and from collective action on the part of physicians. Physicians must not submit false or malicious reports of disruptive behavior.

Physicians who have leadership roles in a health care institution must be sensitive to the unintended effects institutional structures, policies, and practices may have on patient care and professional staff.

As members of the medical staff, physicians should develop and adopt policies or bylaw provisions that:

- (a) Establish a body authorized to receive, review, and act on reports of disruptive behavior, such as a medical staff wellness committee. Members must be required to disclose relevant conflicts of interest and to recuse themselves from a hearing.
- (b) Establish procedural safeguards that protect due process.
- (c) Clearly state principal objectives in terms that ensure high standards of patient care, and promote a professional practice and work environment.
- (d) Clearly describe the behaviors or types of behavior that will prompt intervention.

- (e) Provide a channel for reporting and appropriately recording instances of disruptive behavior. A single incident may not warrant action, but individual reports may help identify a pattern that requires intervention.
- (f) Establish a process to review or verify reports of disruptive behavior.
- (g) Establish a process to notify a physician that his or her behavior has been reported as disruptive, and provide opportunity for the physician to respond to the report.
- (h) Provide for monitoring and assessing whether a physician's disruptive conduct improves after intervention.
- (i) Provide for evaluative and corrective actions that are commensurate with the behavior, such as self-correction and structured rehabilitation. Suspending the individual's responsibilities or privileges should be a mechanism of final resort.
- (j) Identify who will be involved in the various stages of the process, from reviewing reports to notifying physicians and monitoring conduct after intervention.
- (k) Provide clear guidelines for protecting confidentiality.
- (l) Ensure that individuals who report instances of disruptive behavior are appropriately protected.

AMA Principles of Medical Ethics: I,II,VIII

9.5.1 Organized Medical Staff

The organized medical staff performs essential hospital functions even though it may often consist primarily of independent practicing physicians who are not hospital employees. The core responsibilities of the organized medical staff are the promotion of patient safety and the quality of care.

Members of the organized medical staff may choose to act as a group for the purpose of communicating and dealing with the governing board and others with respect to matters that concern the interest of the organized medical staff and its members. This is ethical so long as there is no adverse effect on patient safety and the quality of care.

AMA Principles of Medical Ethics: IV,VI

9.5.2 Staff Privileges

The purpose of medical staff privileging is to improve the quality and efficiency of patient care in the hospital.

Physicians who are involved in granting, denying, or terminating hospital privileges have an ethical responsibility to be guided by concern for the welfare and best interests of patients. They should:

- (a) Base privilege decisions on:

- (i) the candidate's training, experience, demonstrated competence;
 - (ii) the availability of facilities;
 - (iii) the overall medical needs of the community, the hospital, and especially patients.
- (b) Avoid basing privilege decisions on:
- (i) numbers of patients the candidate has admitted to the facility;
 - (ii) economic or insurance status of patients admitted by the candidate;
 - (iii) personal friendships, antagonisms, jurisdictional disputes, or fear of competition.

AMA Principles of Medical Ethics: IV,VI,VII

9.5.3 Accreditation

Physicians who engage in activities that involve the accreditation, approval, or certification of institutions, facilities, and programs that provide patient care or medical education or certify the attainment of specialized professional competence have the ethical responsibility to develop and apply standards that are:

- (a) Relevant, fair, reasonable, and nondiscriminatory.
- (b) Focused on the quality of patient care achieved.

They must avoid adopting or using standards as a means of minimizing competition solely for economic gain.

AMA Principles of Medical Ethics: II,IV,VII

9.5.4 Civil Rights & Medical Professionals

Opportunities in medical society activities or membership, medical education and training, employment and remuneration, academic medicine and all other aspects of professional endeavors must not be denied to any physician or medical trainee because of race, color, religion, creed, ethnic affiliation, national origin, gender or gender identity, sexual orientation, age, family status, or disability or for any other reason unrelated to character, competence, ethics, professional status, or professional activities.

AMA Principles of Medical Ethics: IV

9.5.5 Gender Discrimination in Medicine

Inequality of professional status in medicine among individuals based on gender can compromise patient care, undermine trust, and damage the working environment. Physician leaders in medical schools and

medical institutions should advocate for increased leadership in medicine among individuals of underrepresented genders and equitable compensation for all physicians.

Collectively, physicians should actively advocate for and develop family-friendly policies that:

- (a) Promote fairness in the workplace, including providing for:
 - (i) retraining or other programs that facilitate re-entry by physicians who take time away from their careers to have a family;
 - (ii) on-site child care services for dependent children;
 - (iii) job security for physicians who are temporarily not in practice due to pregnancy or family obligations.

- (b) Promote fairness in academic medical settings by:
 - (i) ensuring that tenure decisions make allowance for family obligations by giving faculty members longer to achieve standards for promotion and tenure;
 - (ii) establish more reasonable guidelines regarding the quantity and timing of published material needed for promotion or tenure that emphasize quality over quantity and encourage the pursuit of careers based on individual talent rather than tenure standards that undervalue teaching ability and overvalue research;
 - (iii) fairly distribute teaching, clinical, research, administrative responsibilities, and access to tenure tracks;
 - (iv) structuring the mentoring process through a fair and visible system.

- (c) Take steps to mitigate gender bias in research and publication.

AMA Principles of Medical Ethics: II, VII

9.6.1 Advertising & Publicity

There are no restrictions on advertising by physicians except those that can be specifically justified to protect the public from deceptive practices. A physician may publicize him or herself as a physician through any commercial publicity or other form of public communication (including any newspaper, magazine, telephone directory, radio, television, direct mail, or other advertising) provided that the communication shall not be misleading because of the omission of necessary material information, shall not contain any false or misleading statement, or shall not otherwise operate to deceive.

Because the public can sometimes be deceived by the use of medical terms or illustrations that are difficult to understand, physicians should design the form of communication to communicate the information contained therein to the public in a readily comprehensible manner. Aggressive, high pressure advertising and publicity should be avoided if they create unjustified medical expectations or are accompanied by deceptive claims. The key issue, however, is whether advertising or publicity, regardless of format or content, is true and not materially misleading.

The communication may include (1) the educational background of the physician, (2) the basis on which fees are determined (including charges for specific services), (3) available credit or other methods of payment, and (4) any other nondeceptive information.

Nothing in this opinion is intended to discourage or to limit advertising and representations which are not false or deceptive within the meaning of Section 5 of the Federal Trade Commission Act. At the same time, however, physicians are advised that certain types of communications have a significant potential for deception and should therefore receive special attention. For example, testimonials of patients as to the physician's skill or the quality of the physician's professional services tend to be deceptive when they do not reflect the results that patients with conditions comparable to the testimoniant's condition generally receive.

Objective claims regarding experience, competence, and the quality of physicians and the services they provide may be made only if they are factually supportable. Similarly, generalized statements of satisfaction with a physician's services may be made if they are representative of the experiences of that physician's patients.

Because physicians have an ethical obligation to share medical advances, it is unlikely that a physician will have a truly exclusive or unique skill or remedy. Claims that imply such a skill or remedy therefore can be deceptive. Statements that a physician has an exclusive or unique skill or remedy in a particular geographic area, if true, however, are permissible. Similarly, a statement that a physician has cured or successfully treated a large number of cases involving a particular serious ailment is deceptive if it implies a certainty of result and creates unjustified and misleading expectations in prospective patients.

Consistent with federal regulatory standards which apply to commercial advertising, a physician who is considering the placement of an advertisement or publicity release, whether in print, radio, or television, should determine in advance that the communication or message is explicitly and implicitly truthful and not misleading. These standards require the advertiser to have a reasonable basis for claims before they are used in advertising. The reasonable basis must be established by those facts known to the advertiser, and those which a reasonable, prudent advertiser should have discovered. Inclusion of the physician's name in advertising may help to assure that these guidelines are being met.

AMA Principles of Medical Ethics: II

9.6.2 Gifts to Physicians from Industry

Relationships among physicians and professional medical organizations and pharmaceutical, biotechnology, and medical device companies help drive innovation in patient care and contribute to the economic well-being of the community to the ultimate benefit of patients and the public. However, an increasingly urgent challenge for both medicine and industry is to devise ways to preserve strong, productive collaborations at the same time that they take clear effective action to prevent relationships that damage public trust and tarnish the reputation of both parties.

Gifts to physicians from industry create conditions that carry the risk of subtly biasing—or being perceived to bias—professional judgment in the care of patients.

To preserve the trust that is fundamental to the patient-physician relationship and public confidence in the profession, physicians should:

- (a) Decline cash gifts in any amount from an entity that has a direct interest in physicians' treatment recommendations.

- (b) Decline any gifts for which reciprocity is expected or implied.
- (c) Accept an in-kind gift for the physician's practice only when the gift:
 - (i) will directly benefit patients, including patient education; and
 - (ii) is of minimal value.
- (d) Academic institutions and residency and fellowship programs may accept special funding on behalf of trainees to support medical students', residents', and fellows' participation in professional meetings, including educational meetings, provided:
 - (i) the program identifies recipients based on independent institutional criteria; and
 - (ii) funds are distributed to recipients without specific attribution to sponsors.

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9.6.3 Incentives to Patients for Referrals

Endorsement by current patients can be a strong incentive to direct new patients to a medical practice and physicians often rely on word of mouth as a source of referrals. However, to be ethically appropriate, word-of-mouth referrals must be voluntary on the part of current patients and should reflect honestly on the practice.

Physicians must not offer financial incentives or other valuable incentives to current patients in exchange for recruitment of other patients. Such incentives can distort the information patients provide and skew the expectations of prospective patients, thus compromising the trust that is the foundation of patient-physician relationships.

AMA Principles of Medical Ethics: I,II,VIII

9.6.4 Sale of Health-Related Products

The sale of health-related products by physicians can offer convenience for patients, but can also pose ethical challenges. "Health-related products" are any products other than prescription items that, according to the manufacturer or distributor, benefit health. "Selling" refers to dispensing items from the physician's office or website in exchange for money or endorsing a product that the patient may order or purchase elsewhere that results in remuneration for the physician.

Physician sale of health-related products raises ethical concerns about financial conflict of interest, risks placing undue pressure on the patient, threatens to erode patient trust, undermine the primary obligation of physicians to serve the interests of their patients before their own, and demean the profession of medicine.

Physicians who choose to sell health-related products from their offices or through their office website or other online venues have ethical obligations to:

- (a) Offer only products whose claims of benefit are based on peer-reviewed literature or other sources of scientific review of efficacy that are unbiased, sound, systematic, and reliable. Physicians should not offer products whose claims to benefit lack scientific validity.
- (b) Address conflict of interest and possible exploitation of patients by:
 - (i) fully disclosing the nature of their financial interest in the sale of the product(s), either in person or through written notification, and informing patients of the availability of the product or other equivalent products elsewhere;
 - (ii) limiting sales to products that serve immediate and pressing needs of their patients (e.g., to avoid requiring a patient on crutches to travel to a local pharmacy to purchase the product). Distributing products free of charge or at cost makes products readily available and helps to eliminate the elements of personal gain and financial conflict of interest that may interfere, or appear to interfere with the physician's independent medical judgment.
- (c) Provide information about the risks, benefits, and limits of scientific knowledge regarding the products in language that is understandable to patients.
- (d) Avoid exclusive distributorship arrangements that make the products available only through physician offices. Physicians should encourage manufacturers to make products widely accessible to patients.

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9.6.5 Sale of Non-Health-Related Goods

Unlike the sale of health-related products, sale of non-health-related products by physicians through their offices or websites, even at cost, does not offer health benefits to patients. The sale of non-health-related goods by physicians presents a conflict of interest and threatens to erode the primary obligation of physicians to serve the interests of their patients before their own. Furthermore, this activity risks placing undue pressure on the patient and demeaning the practice of medicine.

However, such sales can be acceptable under the following limited conditions:

- (a) The goods in question are low cost.
- (b) The physician takes no share in profit from their sale.
- (c) The sale is:
 - (i) for the benefit of community organizations;
 - (ii) conducted in a dignified manner;
 - (iii) conducted in such a way as to assure that patients are not pressured into making purchases;
 - (iv) not a regular part of the physician's business.

AMA Principles of Medical Ethics: I,II

9.6.6 Prescribing & Dispensing Drugs & Devices

In keeping with physicians' ethical responsibility to hold the patient's interests as paramount, in their role as prescribers and dispensers of drugs and devices, physicians should:

- (a) Prescribe drugs, devices, and other treatments based solely on medical considerations, patient need, and reasonable expectations of effectiveness for the particular patient.
- (b) Dispense drugs in their office practices only if such dispensing primarily benefits the patient.
- (c) Avoid direct or indirect influence of financial interests on prescribing decisions by:
 - (i) declining any kind of payment or compensation from a drug company or device manufacturer for prescribing its products, including offers of indemnification;
 - (ii) respecting the patient's freedom to choose where to fill prescriptions. In general, physicians should not refer patients to a pharmacy the physician owns or operates.

AMA Principles of Medical Ethics: II,III,IV,V

9.6.7 Direct-to-Consumer Advertisements of Prescription Drugs

Direct-to-consumer advertising may raise awareness about diseases and treatment and may help inform patients about the availability of new diagnostic tests, drugs, treatments, and devices. However, direct-to-consumer advertising also carries the risk of creating unrealistic expectations for patients and conflicts of interest for physicians, adversely affecting patients' health and safety, and compromising patient physician relationships.

In the context of direct-to-consumer advertising of prescription drugs, physicians individually should:

- (a) Remain objective about advertised tests, drugs, treatments, and devices, avoiding bias for or against advertised products.
- (b) Engage in dialogue with patients who request tests, drugs, treatments, or devices they have seen advertised to:
 - (i) assess and enhance the patient's understanding of the test, drug or device;
 - (ii) educate patients about why an advertised test, drug, or device may not be suitable for them, including providing cost-effectiveness information about different options.
- (c) Resist commercially induced pressure to prescribe tests, drugs, or devices that may not be indicated.
- (d) Obtain informed consent before prescribing an advertised test, drug, or device, in keeping with professional standards.
- (e) Deny requests for an inappropriate test, drug, or device.

- (f) Consider reporting to the sponsoring manufacturer or appropriate authorities direct-to-consumer advertising that:
 - (i) promotes false expectations;
 - (ii) does not enhance consumer education;
 - (iii) conveys unclear, inaccurate, or misleading health education messages;
 - (iv) fails to refer patients to their physicians for additional information;
 - (v) does not identify the target population at risk;
 - (vi) encourages consumer self-diagnosis and treatment.

Collectively, physicians should:

- (g) Encourage and engage in studies that examine the impact of direct-to-consumer advertising on patient health and medical care.
- (h) Whenever possible, assist authorities to enforce existing law by reporting advertisements that do not:
 - (i) provide a fair and balanced discussion of the use of the drug product for the disease, disorder, or condition;
 - (ii) clearly explain warnings, precautions, and potential adverse reactions associated with the drug product;
 - (iii) present summary information in language that can be understood by the consumer
 - (iv) comply with applicable regulations;
 - (v) provide collateral materials to educate both physicians and consumers.

AMA Principles of Medical Ethics: II,III

9.6.8 Direct-to-Consumer Diagnostic Imaging Tests

Diagnostic imaging tests are sometimes marketed directly to consumers before they have been scientifically validated. This can help consumers prevent disease and promote health, but may also expose patients to risk without benefit, create conflicts of interests for physicians, and be abused for profits.

Individually, physicians who offer diagnostic imaging services that have not been scientifically validated and for which a patient has not been referred by another physician have an ethical obligation to:

- (a) Perform a requested diagnostic imaging test only when, in the physician's judgment, the possible benefits of the service outweigh its risks.
- (b) Recognizing that in agreeing to perform diagnostic imaging on request, the physician:

- (i) establishes a patient-physician relationship, with all the ethical and professional obligations such relationship entails;
 - (ii) assumes responsibility for relevant clinical evaluation, including pre- and post-test counseling about the test, its results, and indicated follow-up. Physicians may choose to refer the patient for post-test counseling to an appropriate physician who accepts the patient.
- (c) Obtain the patient's informed consent. In addition to the usual elements of informed consent, the physician should disclose:
- (i) that the diagnostic imaging test has not been validated scientifically;
 - (ii) the inaccuracies inherent in the proposed test;
 - (iii) the possibility of inconclusive results;
 - (iv) the likelihood of false positive and false negative results;
 - (v) circumstances that may require further assessments and additional cost.
- (d) Ensure that the patient's interests are primary and place patient welfare above physician interests when the physician has a financial interest in the imaging facility.
- (e) Ensure that any advertisements for the services are truthful and not misleading or deceptive, in keeping with ethics guidance and applicable law.

Collectively, physicians should:

- (f) Advocate for the conduct of appropriate trials aimed at determining the predictive power of diagnostic imaging tests and their sensitivity and specificity for target populations.
- (g) Develop suitable guidelines for specific diagnostic imaging tests when adequate scientific data become available.

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

9.6.9 Physician Self-Referral

Business arrangements among physicians in the health care marketplace have the potential to benefit patients by enhancing quality of care and access to health care services. However, these arrangements can also be ethically challenging when they create opportunities for self-referral in which patients' medical interests can be in tension with physicians' financial interests. Such arrangements can undermine a robust commitment to professionalism in medicine as well as trust in the profession.

In general, physicians should not refer patients to a health care facility that is outside their office practice and at which they do not directly provide care or services when they have a financial interest in that facility. Physicians who enter into legally permissible contractual relationships—including acquisition of ownership or investment interests in health facilities, products, or equipment; or contracts for service in group practices—are expected to uphold their responsibilities to patients first.

When physicians enter into arrangements that provide opportunities for self-referral they must:

- (a) Ensure that referrals are based on objective, medically relevant criteria.
- (b) Ensure that the arrangement:
 - (i) is structured to enhance access to appropriate, high quality health care services or products; and
 - (ii) within the constraints of applicable law:
 - a. does not require physician-owners/investors to make referrals to the entity or otherwise generate revenues as a condition of participation;
 - b. does not prohibit physician-owners/investors from participating in or referring patients to competing facilities or services; and
 - c. adheres to fair business practices vis-à-vis the medical professional community—for example, by ensuring that the arrangement does not prohibit investment by nonreferring physicians.
- (c) Take steps to mitigate conflicts of interest, including:
 - (i) ensuring that financial benefit is not dependent on the physician-owner/investor’s volume of referrals for services or sales of products;
 - (ii) establishing mechanisms for utilization review to monitor referral practices; and
 - (iii) identifying or if possible making alternate arrangements for care of the patient when conflicts cannot be appropriately managed/mitigated.
- (d) Disclose their financial interest in the facility, product, or equipment to patients; inform them of available alternatives for referral; and assure them that their ongoing care is not conditioned on accepting the recommended referral.

AMA Principles of Medical Ethics: II,III,VIII

9.7.1 Medical Testimony

Medical evidence is critical in a variety of legal and administrative proceedings. As citizens and as professionals with specialized knowledge and experience, physicians have an obligation to assist in the administration of justice.

Whenever physicians serve as witnesses they must:

- (a) Accurately represent their qualifications.
- (b) Testify honestly.
- (c) Not allow their testimony to be influenced by financial compensation. Physicians must not accept compensation that is contingent on the outcome of litigation.

Physicians who testify as fact witnesses in legal claims involving a patient they have treated must hold the patient's medical interests paramount by:

- (d) Protecting the confidentiality of the patient's health information, unless the physician is authorized or legally compelled to disclose the information.
- (e) Delivering honest testimony. This requires that they engage in continuous self-examination to ensure that their testimony represents the facts of the case.
- (f) Declining to testify if the matters could adversely affect their patients' medical interests unless the patient consents or unless ordered to do so by legally constituted authority.
- (g) Considering transferring the care of the patient to another physician if the legal proceedings result in placing the patient and the physician in adversarial positions.

Physicians who testify as expert witnesses must:

- (h) Testify only in areas in which they have appropriate training and recent, substantive experience and knowledge.
- (i) Evaluate cases objectively and provide an independent opinion.
- (j) Ensure that their testimony:
 - (i) reflects current scientific thought and standards of care that have gained acceptance among peers in the relevant field;
 - (ii) appropriately characterizes the theory on which testimony is based if the theory is not widely accepted in the profession;
 - (iii) considers standards that prevailed at the time the event under review occurred when testifying about a standard of care.

Organized medicine, including state and specialty societies and medical licensing boards, has a responsibility to maintain high standards for medical witnesses by assessing claims of false or misleading testimony and issuing disciplinary sanctions as appropriate.

AMA Principles of Medical Ethics: II,IV,V,VII

9.7.2 Court-Initiated Medical Treatment in Criminal Cases

Court-initiated medical treatments raise important questions as to the rights of prisoners, the powers of judges, and the ethical obligations of physicians. Although convicted criminals have fewer rights and protections than other citizens, being convicted of a crime does not deprive an offender of all protections under the law. Court-ordered medical treatments raise the question whether professional ethics permits physicians to cooperate in administering and overseeing such treatment. Physicians have civic duties, but medical ethics do not require a physician to carry out civic duties that contradict fundamental principles of medical ethics, such as the duty to avoid doing harm.

In limited circumstances physicians can ethically participate in court-initiated medical treatments. Individual physicians who provide care under court order should:

- (a) Participate only if the procedure being mandated is therapeutically efficacious and is therefore undoubtedly not a form of punishment or solely a mechanism of social control.
- (b) Treat patients based on sound medical diagnoses, not court-defined behaviors. While a court has the authority to identify criminal behavior, a court does not have the ability to make a medical diagnosis or to determine the type of treatment that will be administered. When the treatment involves in-patient therapy, surgical intervention, or pharmacological treatment, the physician's diagnosis must be confirmed by an independent physician or a panel of physicians not responsible to the state. A second opinion is not necessary in cases of court-ordered counseling or referrals for psychiatric evaluations.
- (c) Decline to provide treatment that is not scientifically validated and consistent with nationally accepted guidelines for clinical practice.
- (d) Be able to conclude, in good conscience and to the best of his or her professional judgment, that to the extent possible the patient voluntarily gave his or her informed consent, recognizing that an element of coercion that is inevitably present. When treatment involves in-patient therapy, surgical intervention, or pharmacological treatment, an independent physician or a panel of physicians not responsible to the state should confirm that voluntary consent was given.

AMA Principles of Medical Ethics: I,III

9.7.3 Capital Punishment

Debate over capital punishment has occurred for centuries and remains a volatile social, political, and legal issue. An individual's opinion on capital punishment is the personal moral decision of the individual. However, as a member of a profession dedicated to preserving life when there is hope of doing so, a physician must not participate in a legally authorized execution.

Physician participation in execution is defined as actions that fall into one or more of the following categories:

- (a) Would directly cause the death of the condemned.
- (b) Would assist, supervise, or contribute to the ability of another individual to directly cause the death of the condemned.
- (c) Could automatically cause an execution to be carried out on a condemned prisoner.

These include, but are not limited to:

- (d) Determining a prisoner's competence to be executed. A physician's medical opinion should be merely one aspect of the information taken into account by a legal decision maker, such as a judge or hearing officer.
- (e) Treating a condemned prisoner who has been declared incompetent to be executed for the purpose of restoring competence, unless a commutation order is issued before treatment begins. The task of re-evaluating the prisoner should be performed by an independent medical examiner.

- (f) Prescribing or administering tranquilizers and other psychotropic agents and medications that are part of the execution procedure.
- (g) Monitoring vital signs on site or remotely (including monitoring electrocardiograms).
- (h) Attending or observing an execution as a physician.
- (i) Rendering of technical advice regarding execution.

and, when the method of execution is lethal injection:

- (j) Selecting injection sites.
- (k) Starting intravenous lines as a port for a lethal injection device.
- (l) Prescribing, preparing, administering, or supervising injection drugs or their doses or types.
- (m) Inspecting, testing, or maintaining lethal injection devices.
- (n) Consulting with or supervising lethal injection personnel.

The following actions do not constitute physician participation in execution:

- (o) Testifying as to the prisoner's medical history and diagnoses or mental state as they relate to competence to stand trial, testifying as to relevant medical evidence during trial, testifying as to medical aspects of aggravating or mitigating circumstances during the penalty phase of a capital case, or testifying as to medical diagnoses as they relate to the legal assessment of competence for execution.
- (p) Certifying death, provided that the condemned has been declared dead by another person.
- (q) Witnessing an execution in a totally nonprofessional capacity.
- (r) Witnessing an execution at the specific voluntary request of the condemned person, provided that the physician observes the execution in a nonprofessional capacity.
- (s) Relieving the acute suffering of a condemned person while awaiting execution, including providing tranquilizers at the specific voluntary request of the condemned person to help relieve pain or anxiety in anticipation of the execution.
- (t) Providing medical intervention to mitigate suffering when an incompetent prisoner is undergoing extreme suffering as a result of psychosis or any other illness.

No physician should be compelled to participate in the process of establishing a prisoner's competence or be involved with treatment of an incompetent, condemned prisoner if such activity is contrary to the physician's personal beliefs. Under those circumstances, physicians should be permitted to transfer care of the prisoner to another physician.

Organ donation by condemned prisoners is permissible only if:

- (u) The decision to donate was made before the prisoner's conviction.

- (v) The donated tissue is harvested after the prisoner has been pronounced dead and the body removed from the death chamber.
- (w) Physicians do not provide advice on modifying the method of execution for any individual to facilitate donation.

AMA Principles of Medical Ethics: I

9.7.4 Physician Participation in Interrogation

Interrogation is defined as questioning related to law enforcement or to military and national security intelligence gathering, designed to prevent harm or danger to individuals, the public, or national security. Interrogations of criminal suspects, prisoners of war, or any other individuals who are being held involuntarily (“detainees”) are distinct from questioning used by physicians to assess an individual’s physical or mental condition. To be appropriate, interrogations must avoid the use of coercion—that is, threatening or causing harm through physical injury or mental suffering.

Physicians who engage in any activity that relies on their medical knowledge and skills must continue to uphold principles of medical ethics. Questions about the propriety of physician participation in interrogations and in the development of interrogation strategies may be addressed by balancing obligations to individuals with obligations to protect third parties and the public. The further removed the physician is from direct involvement with a detainee, the more justifiable is a role serving the public interest.

Applying this general approach, physician involvement with interrogations during law enforcement or intelligence gathering should be guided by the following:

- (a) Physicians may perform physical and mental assessments of detainees to determine the need for and to provide medical care. When so doing, physicians must disclose to the detainee the extent to which others have access to information included in medical records. Treatment must never be conditional on a patient’s participation in an interrogation.
- (b) Physicians must neither conduct nor directly participate in an interrogation, because a role as physician-interrogator undermines the physician’s role as healer and thereby erodes trust in the individual physician-interrogator and in the medical profession.
- (c) Physicians must not monitor interrogations with the intention of intervening in the process, because this constitutes direct participation in interrogation.
- (d) Physicians may participate in developing effective interrogation strategies for general training purposes. These strategies must not threaten or cause physical injury or mental suffering and must be humane and respect the rights of individuals.

When physicians have reason to believe that interrogations are coercive, they must report their observations to the appropriate authorities. If authorities are aware of coercive interrogations but have not intervened, physicians are ethically obligated to report the offenses to independent authorities that have the power to investigate or adjudicate such allegations.

AMA Principles of Medical Ethics: I,III,VII,VIII

9.7.5 Torture

Torture refers to the deliberate, systematic, or wanton administration of cruel, inhumane, and degrading treatments or punishments during imprisonment or detainment.

Physicians must oppose and must not participate in torture for any reason. Participation in torture includes, but is not limited to, providing or withholding any services, substances, or knowledge to facilitate the practice of torture. Physicians must not be present when torture is used or threatened.

Physicians may treat prisoners or detainees if doing so is in their best interest, but physicians should not treat individuals to verify their health so that torture can begin or continue.

Physicians who treat torture victims should not be persecuted.

Physicians should help provide support for victims of torture and, whenever possible, strive to change situations in which torture is practiced or the potential for torture is great.

AMA Principles of Medical Ethics: I,III