American Medical Association
Physicians dedicated to the health of America

Council on Ethical and Judicial Affairs

1994 Edition

Code of Medical Ethics

Current Opinions with Annotations

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Including the
Principles of Medical Ethics,
Fundamental Elements of the Patient-Physician Relationship and
Rules of the Council on Ethical and Judicial Affairs

Annotations prepared by the
Southern Illinois University Schools of Medicine and Law

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Preface

This edition of Current Opinions with Annotations of the Council on Ethical and Judicial Affairs replaces all previous editions of Current Opinions. It is one component of the American Medical Association's Code of Ethics; the other components are the Principles of Medical Ethics, Fundamental Elements of the Patient-Physician Relationship, and the Reports of the Council on Ethical and Judicial Affairs. The Principles and Fundamental Elements are published in Current Opinions with Annotations. Reports are published separately.

The Principles of Medical Ethics are the primary component of the Code. They establish the core ethical principles from which the other components of the Code are derived. The Principles were most recently revised in 1980.

Fundamental Elements of the Patient-Physician Relationship enunciates the basic rights to which patients are entitled from their physicians.

Current Opinions with Annotations reflects the application of the Principles of Medical Ethics to more than 125 specific ethical issues in medicine, including health care rationing, genetic testing, withdrawal of life-sustaining treatment, and family violence. Much as courts of law elaborate on constitutional principles in their opinions, the Council develops the meaning of the Principles of Medical Ethics in its opinions. Accordingly, each opinion is followed by one or more roman numerals that identify the Principle(s) from which the opinion is derived. Each opinion is also followed by a list of annotations that reflect citations to the opinion in judicial rulings and the medical, ethical, and legal literature.

The Reports discuss the rationale behind many of the Council's opinions, providing a detailed analysis of the relevant ethical considerations.

All four components of the AMA's Code of Ethics need to be consulted to determine the Association's positions on ethical issues. In addition, the AMA's House of Delegates at times issues statements on ethical issues. These statements are contained in a separate publication, the *AMA Policy Compendium*. Because the Council on Ethical and Judicial Affairs is responsible for determining the AMA's positions on ethical issues, statements by the House of Delegates should be construed as the view of the House of Delegates but not as the ethics policy of the Association.

Medical ethics involve the professional responsibilities and obligations of physicians. Behavior relating to medical etiquette or custom is not addressed in Current Opinions with Annotations. The opinions which follow are intended as guides to responsible professional behavior,

but they are not presented as the sole or only route to medical morality.

No one Principle of Medical Ethics can stand alone or be individually applied to a situation. In all instances, it is the overall intent and influence of the Principles of Medical Ethics which shall measure ethical behavior for the physician. Council opinions are issued under its authority to interpret the Principles of Medical Ethics and to investigate general ethical conditions and all matters pertaining to the relations of physicians to one another and to the public.

The Council on Ethical and Judicial Affairs encourages comments and suggestions for future editions of this publication.

History

The Oath of Hippocrates, a brief statement of principles, has come down through history as a living statement of ideals to be cherished by the physician. This Oath was conceived some time during the period of Grecian greatness, probably in the fifth century B.C. It protected rights of the patient and appealed to the inner and finer instincts of the physician without imposing sanctions or penalties on him or her. Other civilizations subsequently developed written principles, but the Oath of Hippocrates (Christianized in the tenth or eleventh century A.D. to eliminate reference to pagan gods) has remained in Western Civilization as an expression of ideal conduct for the physician.

The most significant contribution to Western medical ethical history subsequent to Hippocrates was made by Thomas Percival, an English physician, philosopher, and writer. In 1803, he published his Code of Medical Ethics. His personality, his interest in sociological matters, and his close association with the Manchester Infirmary led to the preparation of a "scheme of professional conduct relative to hospitals and other charities" from which he drafted the code which bears his name.

At the first official meeting of the American Medical Association at Philadelphia in 1847, the two principal items of business were the establishment of a code of ethics and the creation of minimum requirements for medical education and training. Although the Medical Society of the State of New York and the Medico-Chirurgical Society of Baltimore had formal written codes of medical ethics prior to this time, it is clear the AMA's first adopted Code of Ethics was based on Percival's Code.

In general, the language and concepts of the original Code adopted by the Association in 1847 remained the same throughout the years. There were revisions, of course, which reflected the temper of the times and the eternal quest to express basic concepts with clarity. Major revisions did occur in 1903, 1912, and 1947.

In December 1955, an attempt was made to distinguish medical ethics from matters of etiquette. A draft of a two-part code seeking to accomplish this was submitted to the House of Delegates at that time but was not accepted. This proposal was, in effect, a separation of then existing statements found in the Principles into two categories. Little or no change was made in the language of the forty-eight sections of the Principles.

Subsequently, in June 1956, a seemingly radical proposal was submit-

ted to the House of Delegates for consideration. This proposal, a short version of the Principles, was discussed at the December 1956 session of the House after wide publication and broad consideration among members of the medical profession. It was postponed for final consideration until the June 1957 meeting of the House of Delegates, when the short version was adopted.

The format of the Principles adopted in June 1957 is a change from the format of the Principles promulgated by Percival in 1803 and accepted by the Association in 1847. Ten short sections, preceded by a preamble, "succinctly express the fundamental concepts embodied in the present (1955) Principles," according to the report of the Council on Constitution and Bylaws. That Council assured the House of Delegates in its June 1957 report that "every basic principle has been preserved; on the other hand, as much as possible of the prolixity and ambiguity which in the past obstructed ready explanation, practical codification and particular selection of basic concepts has been eliminated."

In 1977, the Judicial Council recommended to the House of Delegates that the AMA Principles of Medical Ethics be revised to clarify and update the language, to eliminate reference to gender, and to seek a proper and reasonable balance between professional standards and contemporary legal standards in our changing society. Given the desire of the Judicial Council for a new version of the Principles to be widely accepted and accurately understood, in 1978 the Judicial Council recommended that a special committee of the House be appointed to consider such a revision. This was done in 1980, and the House of Delegates adopted the revision of the AMA Principles of Medical Ethics at its Annual Meeting in June 1980.

In June 1985, the Judicial Council became the Council on Ethical and Judicial Affairs.

Guide to Use of Annotations

Over the years, the AMA Principles of Medical Ethics and the Current Opinions of the Council on Ethical and Judicial Affairs have emerged as an important source of guidance for responsible professional medical behavior, as well as the primary compendium of medical professional value statements in the United States.

The Opinions included in this volume are derived from two sources. The Council may issue Opinions directly at any time, usually during the Annual and Interim meetings of the AMA House of Delegates. Other Opinions are derived from the conclusions or recommendations of longer reports of the Council that are published separately in *Reports of the Council on Ethical and Judicial Affairs* (available from the AMA). Many of the reports from which Opinions are derived are also published in peer-reviewed medical journals.

In this volume, an Opinion that is derived from a longer report is followed by a citation to that report as published in *Reports* and, if applicable, in a peer-reviewed medical journal. Some reports from 1993 and 1994 were under consideration for publication in peer-reviewed journals when this book went to press. Opinions that are issued directly rather than derived from reports are followed by information giving the date of issuance or most recent revision. For some of the older Opinions, however, this information is not available.

The impact of the Principles and Opinions has been significant. In this regard, attorneys and judges have shown an increasing willingness to look to the Principles and Opinions as a predicate for legal advocacy and decisionmaking in matters of health care law and litigation.

Against this backdrop of increasing reliance on the Principles and Opinions, these annotations have been prepared. They are designed to provide a research and reference tool for practitioners, scholars, jurists, and others who seek ready access to the Principles and Opinions in their work.

The annotations include summaries of all reported court decisions, and selected state attorney general opinions, which make substantive reference to the Principles or Opinions. Additionally, the annotations summarize selected articles from the medical, legal, and ethical literature.

These materials were gathered on the basis of carefully structured searches of a variety of computerized research services including WESTLAW, LEXIS, and MEDLINE. Further, more generalized review of

various medical and legal journals resulted in evaluation of approximately 1,000 articles. The annotations are inclusive through December 1993.

The annotations have been prepared to maximize their usefulness as reference and research tools. After a brief synopsis of the facts and legal issues, each case annotation focuses on the court's reference to the Principle(s) or Opinion(s) and the role it played in the decision. In addition to the particular source referred to by the court, case annotations include, where necessary, a cross reference to the relevant provision(s) of the present version of the Principles and Opinions.

Journal annotations provide a general summary of the subject article, along with an indication of the specific Principle(s) or Opinion(s) referenced therein. Again, a cross-reference feature is included. For convenience, consistent terminology is used in the journal annotations. When an author generally refers to the Principle or Opinion, the term "references" is used. When a Principle or Opinion is "cited," this term is used. Finally, if an author directly quotes from a Principle or a Current Opinion, then the annotation so indicates.

With respect to both case and journal annotations, specific page references are provided to identify where the Principle(s) or Current Opinion(s) are discussed. This feature is intended to facilitate efficient use of these annotations. A Table of Cases and a Table of Articles also have been compiled to further enhance the usefulness of this compendium.

It is important to recognize that the Principle(s) and Opinion(s) have a long and evolving history. Many of the cases included herein refer to older versions of the Principles and Opinions, some of which have been eliminated or have changed considerably over the years. Nonetheless, these cases may be valuable to the user. Efforts were made to identify the most appropriate provisions of the present Principles and Opinions to which to assign these cases. However, in some instances the correspondence is not exact and the user will need to review carefully the particular case under consideration with respect to the user's specific interests.

The annotators would like to express appreciation to Charles Ellington, Frank Choi, Michelle Dillon, Thomas Morrow, and Susan Tedrick, who provided valuable research, editing and other assistance on this project. Finally, we owe a special debt of thanks to Pamela Graham of the School of Law who handled the difficult task of entry of annotations into the database and preparation of the final manuscript with skill, enthusiasm, and infinite patience.

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June, 1994

American Medical Association
Principles of Medical Ethics

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, of 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.

American Medical Association

Principles of Medical Ethics

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.

Ind. 1991 Plaintiff sued physician for injuries caused by physician's patient as the result of medication administered by the physician. Weighing (1) the relationship between the parties, (2) the reasonable foreseeability of harm to the injured party, and (3) public policy, the court held that a physician generally owes no duty to unknown third parties who may be injured by the physician's treatment of a patient. Concurring opinion quoted the Preamble which mandates that a physician "recognize responsibility...to society" arguing that there is no absolute immunity to third-party suits. *Webb v. Jarvis, 575 N.E.2d 992, 998.*

N.J. 1979 In wrongful death action against a psychiatrist whose patient murdered plaintiff's decedent, the court concluded, in accord with Principle 9 (1957) [now Principle IV], that a psychiatrist may owe a duty to warn potential victims of possible danger from psychiatrist's patient despite the general emphasis on confidentiality. The court also noted the Preamble and Principles 1 and 3 (1957) [now revised Preamble, Principle I and Opinion 5.05] in discussing the psychiatrist-patient relationship. *McIntosh v. Milano, 168 N.J. Super. 466, 403 A.2d 500, 510, 512-13.*

Journal 1991 Examines the informed consent doctrine and how it was broadened in *Moore v. Regents of the University of California.* Concludes that, in California, under *Moore*, a physician must disclose to patients any economic or research interest he or she might have in the patient's medical treatment. Quotes Preamble to Principles. Guise, *Expansion of the Scope of Disclosure Required Under the Informed Consent Doctrine: Moore v. The Regents of the University of California, 28 San Diego L. Rev. 455, 462 (1991).*

Journal 1990 Discusses the moral dilemma in deciding whether to withdraw artificial nutrition and hydration from a patient and the appropriate role of the judiciary. States that part of the reason for judicial activism in this private area is because legislatures have not adequately expressed public policy. Concludes that judicial decisions do not represent the moral viewpoint of society and that moral pronouncements should not be made in the courtroom. Quotes Preamble, Principles I, II, III, IV, V, VI, and VII, and Opinion 2.20. Peccarelli, *A Moral Dilemma: The Role of Judicial Intervention in Withholding or Withdrawing Nutrition and Hydration, 23 John Marshall L. Rev. 537, 539, 540, 541 (1990).*

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Ohio 1991 State medical board revoked license of physician who had consensual sexual relations with his patient. The court upheld the board's ruling that this violated Principles I, II and IV. Dissenting judge, citing AMA Council on Ethical and Judicial Affairs, Sexual Misconduct in the Practice of Medicine, 266 JAMA 2741, 2745 (Nov. 20, 1991) [now Opinion 8.14], argued that until 1991, the AMA did not clearly deem sexual contact with a patient unethical. *Pons v. Ohio State Medical Bd., 66 Ohio St. 3d 619, 623, 625, 614 N.E.2d 748, 752, 753.*

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Journal 1986 Observes that the AMA policy on capital punishment expressly forbids psychiatrists from making determinations of competency for execution. Such a practice places the psychiatrist in the position of a "double agent," employed by the state, yet required to serve the patient. Compares the psychiatrist's determination of competency for execution to the behavior of Nazi physicians, and condemns as inherently dishonest any therapy not grounded in the patient's best interests. References Principle I and Opinion 2.06. Sargent, *Treating the Condemned to Death, 16 Hastings Center Rep. 5, 5 (Dec. 1986).*

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.

Cal. App. 1956 Physician-petitioner sought mandamus against local medical association whose bylaws provided for the expulsion of any member who violated the Principles. Petitioner had been expelled under the provision for alleged violation of Principles Ch. III, Art IV, Sec.4 (1947) [now Opinions 9.04 and 9.07] for making disparaging statements regarding another physician in a report used in judicial proceedings. In holding that application of the provision to petitioner was contrary to public policy, the court noted that the physician's statements had been made at the request of a civil litigant and enjoyed a statutory testimonial privilege. Further, the court found that the American Medical Association's right to formulate ethical principles did not extend to defining the duties of witnesses. Expulsion was also based on petitioner's critical comments about other physicians overheard by their patients in violation of Principles Ch. III, Art. IV, Sec.1 (1947) [now Principle II and Opinion 9.04]. The court found application of this Principle under the circumstances reasonable and not contrary to public policy. *Bernstein v. Alameda-Contra Costa Medical Ass'n, 139 Cal. App. 2d 241, 293 P.2d 862, 863, 863 nn.1, 2 865 nn.4, 6, 866, 866 n.8, 867.*

Ill. App. 1986 Defense attorney in product liability suit was held in contempt of court for conducting ex parte discussions with plaintiff-patient's treating physician without patient's consent and contrary to authorized methods of discovery. The court held that the strong public policy favoring physician-patient confidentiality articulated in Principles II and IV and Opinions 5.05, 5.06, 5.07, and 5.08 justified a rule against such ex parte discussions. Further, the court held that the public has the right to rely on physicians to faithfully execute their ethical obligations. *Petrillo v. Syntex Laboratories, Inc., 148 Ill. App. 3d 581, 499 N.E.2d 952, 957, 958, 959.*

Ky. App. 1978 Plaintiff-physician attempted to enjoin defendant medical society from expelling him for actions contrary to a variety of Principles, the most relevant to his alleged unethical behavior being Principle 4 (1957) [now Principles II and

III]. After reviewing the procedures followed by the medical society in considering the evidence pertaining to the charges, the court affirmed judgment dismissing the action, concluding that plaintiff was not deprived of due process. *Kirk v. Jefferson County Medical Soc'y, 577 S.W.2d 419, 421.*

Mass. 1955 Plaintiff-physician was charged under state licensing statute by defendant-board with conspiracy and fee-splitting. Both parties sought a declaratory judgment as to whether the defendant-board had jurisdiction to determine plaintiff's guilt or innocence. In holding that the board was qualified to determine if plaintiff's actions constituted "gross misconduct" under the statute, the court referred to Principles Ch.I, Secs.1 and 6 (1947) [now Principle II and Opinion 6.02] delineating, in part, limitations on payment for medical services. These provisions, the court said, reflected the medical profession's understanding of its "peculiar obligations." *Forziati v. Board of Registration in Medicine, 333 Mass. 125, 128 N.E.2d 789, 791.*

Mich. App. 1968 Physician was properly dismissed from hospital staff for violating Principle 4 (1957) [now Principle II and Opinion 9.11] when on numerous occasions physician "vilified" other physicians, swore and screamed in the hospital, and quarreled with staff and hospital visitors. *Anderson v. Board of Trustees of Caro Community Hosp., 10 Mich. App. 348, 159 N.W.2d 347, 348-50.*

Minn. 1970 Defendant-physician appealed order to answer interrogatories, claiming that a medical malpractice plaintiff is prohibited from compelling expert testimony from a defendant to prove a charge of malpractice without calling other medical witnesses. In holding that a defendant could be compelled to provide expert medical opinion in response to interrogatories, the court quoted Principle 1 (1957) [now Principle II and Opinion 8.12] for the proposition that physicians owe a duty of disclosure to their patients. *Anderson v. Florence, 288 Minn. 351, 181 N.W.2d 873, 880, 880 n.7.*

N.Y. Sup. Ct. 1965 Physician sued publishing company to bar insertion of advertisement for baby and child care products in physician's book, seeking declaration that book contract was void to the extent that it allowed inclusion of such an advertisement. Physician asserted that the advertisement was contrary to public policy, citing Opinions and Reports of the Judicial Council Sec. 5, Para. 29 (1965) [now Opinion 5.02] which stated that a doctor should not lend his name to any product. In rejecting the physician's claim, the court was willing to give careful consideration to the Association's view but concluded that it did not, in itself, constitute an expression of public policy. *Spock v. Pocket Books, Inc., 48 Misc. 2d 812, 266 N.Y.S.2d 77, 79.*

Ohio 1991 State medical board revoked license of physician who had consensual sexual relations with his patient. The court upheld the board's ruling that this violated Principles I, II and IV. Dissenting judge, citing AMA Council on Ethical and Judicial Affairs, Sexual Misconduct in the Practice of Medicine, 266 JAMA 2741, 2745 (Nov. 20, 1991) [now Opinion 8.14], argued that until 1991, the AMA did not clearly deem sexual contact with a patient unethical. *Pons v. Ohio State Medical Bd., 66 Ohio St. 3d 619, 623, 625, 614 N.E.2d 748, 752, 753.*

Ohio 1980 A physician, charged with violating the state medical licensing statute by distributing controlled substances without a proper license and writing prescriptions for narcotics in the name of one person when they were intended for another, challenged the state medical board's decision to suspend his license and place him on two years probation. Under the statute, a physician could be disciplined for various activities including "violation of any provision of a code of ethics of a national professional organization" such as the American Medical Association. The board found in part that the physician's actions violated Principles 4 and 7 (1957) [now Principles II and III and Opinions 6.04 and 9.04]. The trial court reversed, holding that the board had insufficient evidence for its decision, and the court of appeals affirmed. On appeal, the supreme court held that expert testimony was not required at a hearing before a medical licensing board because they were experts and could determine for themselves whether the Principles had been violated. *Arlen v. State, 61 Ohio St. 2d 168, 399 N.E.2d 1251, 1252, 1253-54.*

Journal 1993 Evaluates self-policing mechanisms for addressing incompetent and unethical behavior in the medical profession. Discusses the problems physicians may encounter by exposing the errant colleague, such as harm to the reporting physician's reputation and the fear of litigation. States that problems involving physician

competency and unethical behavior should be investigated, and that physicians should take personal responsibility for reporting problems they observe. References Principle II and Opinions 8.14 and 9.031. Morreim, *Am I My Brother's Warden? Responding to the Unethical or Incompetent Colleague, 23 Hastings Center Rep. 19, 23 (May/June 1993).*

Journal 1991 Examines the issues surrounding judicial use of professional ethics codes in private litigation. Explores the history and major characteristics of the "professions." Explains how courts currently apply codes of ethics. Concludes that judges should more extensively use professional ethics codes to define public policy, standards of care, and legal causes of action. Quotes Principle II and Opinion 2.19. Note, *Professional Ethics Codes in Court: Redefining the Social Contract Between the Public and the Professions, 25 Georgia L. Rev. 1327, 1335, 1351 (1991).*

Journal 1990 Examines the extent to which forensic psychiatrists are consulted in medical malpractice cases. Considers the appropriate standard of care, particularly for psychiatric malpractice cases, and the problems associated with its determination. In cases where a practitioner was negligent, criteria for establishing damages are considered. References Principles II and IV. Modlin, *Forensic Psychiatry and Malpractice, 18 Bull. Am. Acad. Psychiatry Law 153, 161 (1990).*

Journal 1990 Discusses the moral dilemma in deciding whether to withdraw artificial nutrition and hydration from a patient and the appropriate role of the judiciary. States that part of the reason for judicial activism in this private area is because legislatures have not adequately expressed public policy. Concludes that judicial decisions do not represent the moral viewpoint of society and that moral pronouncements should not be made in the courtroom. Quotes Preamble, Principles I, II, III, IV, V, VI, and VII, and Opinion 2.20. Peccarelli, *A Moral Dilemma: The Role of Judicial Intervention in Withholding or Withdrawing Nutrition and Hydration, 23 John Marshall L. Rev. 537, 539, 540, 541 (1990).*

Journal 1989 Discusses the history of the physician-patient privilege up through changes implemented under the Ohio Tort Reform Act of 1987. Aspects of the physician-patient privilege that are most significantly affected by this Tort Reform Act are highlighted, with recommendations for further refinement of the privilege in Ohio. Quotes Principles II, IV and Opinion 5.05. Note, *The Ohio Physician-Patient Privilege: Modified, Revised, and Defined, 49 Ohio St. L. J. 1147, 1167 (1989).*

Journal 1985 Focuses on the importance of patient autonomy in medical decision-making. Initially describes how existing doctrines protect the value of autonomy in the context of the physician-patient relationship, then examines various problems in the current protective scheme. Case law is evaluated wherein enhanced protection is afforded to patient autonomy. Concludes by recommending the creation of an independent articulable protected interest in patient autonomy. Quotes Principles II and IV. Cites Opinions 4.04 (1984) [now Opinion 8.08] and 6.03 (1984) [now Opinion 6.02]. Shultz, *From Informed Consent to Patient Choice: A New Protected Interest, 95 Yale L. J. 219, 275 (1985).*

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.

Ariz. 1965 Physician appealed denial of medical license which was based on alleged violations of local medical society rules and Principles 3, 5, and 10 (1957) [now Principles III and VII, and Opinions 3.01, 8.11, and 9.06]. Alleged violations included treating a patient without first obtaining a prior treating physician's permission, inadequate patient care, performing operations without hospital privileges, and signing the medical record of a deceased patient who had been treated by interns. The court held that the evidence failed to show any clear violation of the Principles and that a local medical society had no right to prescribe a code of ethics for state licensing purposes. *Arizona State Bd. of Medical Examiners v. Clark, 97 Ariz. 205, 398 P.2d 908, 914-15, 915 n.3.*

Ky. App. 1978 Plaintiff-physician attempted to enjoin defendant medical society from expelling him for actions contrary to a variety of Principles, the most relevant

to his alleged unethical behavior being Principle 4 (1957) [now Principles II and III]. After reviewing the procedures followed by the medical society in considering the evidence pertaining to the charges, the court affirmed judgment dismissing the action, concluding that plaintiff was not deprived of due process. *Kirk v. Jefferson County Medical Soc'y, 577 S.W.2d 419, 421.*

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Journal 1991 Examines the wisdom and likely results of medicalizing psychoactive drugs of abuse. Notes that claimed advantages of medicalizing recreational drugs could be more efficiently achieved through legalization. Concludes that although many physicians would consider prescribing psychoactive drugs of abuse for drug abusers in order to end dependence, few would be willing to prescribe such drugs for recreational purposes. Quotes Principle III. Levine, *Medicalization of Psychoactive Substance Use and the Doctor-Patient Relationship, 69 Milbank Quarterly 623, 624 (1991).*

Journal 1990 Discusses the moral dilemma in deciding whether to withdraw artificial nutrition and hydration from a patient and the appropriate role of the judiciary. States that part of the reason for judicial activism in this private area is because legislatures have not adequately expressed public policy. Concludes that judicial decisions do not represent the moral viewpoint of society and that moral pronouncements should not be made in the courtroom. Quotes Preamble, Principles I, II, III, IV, V, VI, and VII, and Opinion 2.20. Peccarelli, *A Moral Dilemma: The Role of Judicial Intervention in Withholding or Withdrawing Nutrition and Hydration, 23 John Marshall L. Rev. 537, 539, 540, 541 (1990).*

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

D. Kan. 1991 With apparent reliance on Principle IV and Opinion 5.05, plaintiff claimed that other than in discovery or judicial proceedings, the physician-patient privilege is absolute and precludes ex parte communications with defense counsel. While recognizing the confidential nature of the physician-patient relationship, the court held that the ethical standards promulgated by the AMA are not binding law and that, where a litigant-patient has placed his or her medical status in issue, the physician is released from the constraints imposed by the physician-patient relationship for the purposes of the litigation. *Bryant v. Hilst, 136 F.R.D. 487, 490.*

N.D. Ohio 1965 Plaintiff-patient alleged that the defendant-malpractice insurer induced physician to reveal confidential information about plaintiff on pretext that plaintiff filed a malpractice suit. In denying defendant's motion for reconsideration of the court's earlier opinion, the court confirmed its holding that actions of a third party inducing a physician to divulge confidential information may result in liability to the patient. In so holding, the court quoted (with incorrect citation to Ch. II, Sec.1) Principles Ch. I, Sec.2 (1912), [now Principle IV and Opinion 5.08], to emphasize the medical profession's established views regarding confidentiality. *Hammonds v. Aetna Casualty & Sur. Co., 243 F. Supp. 793, 803.*

M.D. Pa. 1987 Plaintiff in a medical malpractice action sought to preclude his treat-

ing physicians from serving as defendant's expert witnesses at trial. The court held that defense counsel's failure to provide prior notice of ex parte communication with plaintiff's treating physicians barred their use as defense experts. Referring to Petrillo v. Syntex Laboratories, Inc., 148 Ill. App. 3d 581, 499 N.E. 2d 952 (1986), the court noted that the court there favorably cited Principle IV and Opinions 5.05, 5.06, and 5.07 (1984) in support of a public policy protecting confidentiality between physician and patient and against ex parte discussion. *Manion v. N.P.W. Medical Ctr. of N.E. Pa., Inc., 676 F.Supp. 585, 591.*

Ala. 1973 Physician revealed patient information to the patient's employer, contrary to instructions of patient. Patient sued for breach of fiduciary duty. Citing Principle 9 (1957) [now Principle IV and Opinion 5.05] as well as cases from other states, the court held that even in the absence of a testimonial privilege statute, as a matter of public policy, a physician has a fiduciary duty not to make extrajudicial disclosures of patient information acquired in the course of treatment unless the public interest or the private interest of the patient demands otherwise. In holding that the physician had breached his contract with patient, the court found the Principles together with state licensing requirements sufficient to establish the public policy of confidentiality. *Horne v. Patton, 291 Ala. 701, 287 So. 2d 824, 829, 832.*

Alaska 1977 Physician-school board member failed to fully comply with state's conflict of interest law by refusing to reveal the names of patients from whom he had received over $100 in income. The physician claimed a legal privilege or ethical duty not to disclose the information under Principle 9 (1957) [now Principle IV and Opinion 5.05] and, alternatively, that the conflict of interest law unconstitutionally invaded a patient's right to privacy. The court held that disclosure was not barred by a legal privilege or ethical mandate, but that the conflict of interest law unconstitutionally invaded patient privacy due to the absence of protective regulations. In ruling on the ethical duty issue, the court noted that under Alaska law, a physician's license may be revoked for violating the Principles. However, the court found this licensing provision irrelevant to the privileged relationship exception in the conflict of interest law. The court found that otherwise the privilege exception in the statute could be changed by the American Medical Association, a private organization, simply by amending the Principles. *Falcon v. Alaska Pub. Offices Comm'n, 570 P.2d 469, 474 n.13.*

Ariz. App. 1992 Employer argued that workers' compensation statute abrogated the physician-patient privilege statute, permitting ex parte communications with employee's treating physician. Recognizing that a physician is ethically bound to protect the confidentiality of privileged information pursuant to Principle IV, yet lacks the legal training to distinguish between privileged and unprivileged information, the court held that a claimant has the right to insist that his attorney be present when his employer interviews the employee's physician. *Salt River Project v. Industrial Comm'n, 1992 Ariz. App. LEXIS 323, 129 Ariz. Adv. Rep. 39.*

Ariz. App. 1989 In a medical malpractice action, defense counsel interviewed several of plaintiff's treating physicians ex parte and notified plaintiff of this in preparation for a medical liability review panel hearing. Plaintiff moved to bar all testimony by those physicians and to disqualify defense counsel from representing defendants. The appellate court noted a physician's obligation of confidentiality pursuant to Principle IV and Opinion 5.05 and held that "defense counsel in a medical malpractice action may not engage in non-consensual ex parte communications with plaintiff's treating physicians." *Duquette v. Superior Court, 161 Ariz. 269, 778 P.2d 634, 641.*

Cal. 1976 Parents sued psychotherapists to recover for murder of daughter by psychiatric patient, alleging that failure to warn victim of patient's violent threat was a proximate cause of her death. In considering whether such a revelation would have been a violation of professional ethics, the Court noted that Principle 9 (1957) [now Principle IV and Opinion 5.05] recognized that the confidential nature of a physician-patient communication must yield when disclosure is necessary to protect an individual or community as a whole. The court concluded that, in the circumstances of this case, disclosure would not have violated medical ethics and held that psychotherapists are under a duty to warn when they determine or should determine that a patient poses a serious danger of violence to someone else. *Tarasoff v. Regents of Univ. of Cal., 17 Cal.3d 425, 551 P.2d 334, 347, 131 Cal. Rptr. 14, 27.*