Konrad Jackson

From: Rep. Kurt Olson
Sent: Thursday, March 10, 2011 11:30 PM
To: Konrad Jackson
Subject: FW: Additional ASMA Testimony - HB122
Attachments: Code of Medical Ethics.pdf

From: ASMA [asma@asmadocs.org]
Sent: Thursday, March 10, 2011 4:24 PM
To: Rep. Kurt Olson
Cc: Rep. Craig Johnson; Rep. Dan Saddler; Rep. Steve Thompson; Rep. Lindsey Holmes; Rep. Bob Miller; Representative Mike Chenault (Representative_Mike_Chinault@legis.state.ak.us)
Subject: Re: Additional ASMA Testimony - HB122

Chair Olson;

Here is the additional written ASMA testimony that I referred to during yesterday's hearing on HB122 that I offered to send in lieu of providing oral testimony due to the time constraints.

On Page 3, Sec 08.45.005 creates the duties for the new board proposed. In 08.45.005 (5), the board is granted authority to define "physician-patient relationship" for the purpose of Sec. 08.45.045(5) (which created the new scope of practice for naturopaths to prescribe, give vaccinations, provide hormones , and to provide medical devices).

Other activities described in Sec. 08.45.045 would also be provided in the environment of the "physician-patient relationship" (eg. physical examinations, administer therapies, school physicals, etc.). This raises the issue of why the "physician- patient relationship" do not pertain to those activities. Does it mean "physician-patient relationship" is not required to perform those activities other than those in Sec. 08.45.045 (5)?

Research of current Alaska Statutes shows they do not contain a definition of "physician-patient relationship" . In my experience and that of ASMA's, out-side general counsel, Roger Holmes, the physician-patient relationship comes up in the realm of physician medical liability claims. In general, Alaska's courts have indicated that, in–effect, it is the patient who determines when a physician patient relationship exists.

It appears that the State Medical Board does not have the direct authority to establish such a definition, but we have not researched other boards that govern the other medical care providers.

It would seem that this delegation to a particular board is unprecedented and this would be an issue that needs to be addressed on more universal scale by the Legislature. The definition of what constitutes a relationship between a medical care provider and a patient is very complex. As a testament to the complexity, I've attached the pertinent pages of the American Medical Association Code of Medical Ethics 2010-2011 Edition. This includes the Principles of Medical Ethics VIII pages lxxi-lxxv; and Opinions on the Patient- Physician Relationship 10.01-10.05, Pages 367 through 384.

ASMA, not knowing the intent of defining the term "physician-patient relationship" in HB122, urges that, due to the complexity of this issue and the more universal interest in this

issue, HB122 not include language to delegate that authority to the naturopathic board. ASMA recommends that this issue be explored and addressed outside of HB122.

This is the approach that has been taken in addressing issues that pertain to civil malpractice actions brought against “health care providers” that includes all types of licensed medical care providers. (Please see AS 09.55.540 and AS 09.55.556 for examples of such issues that pertain to “standard of care” and “informed consent”.)

Please let me know should you have any questions.

Sincerely

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March 9, 2011

Honorable Kurt Olson
State of Alaska
House of Representatives
Chair, House Labor and Commerce Committee
State Capitol, Room 24
Juneau, AK 99801

RE: HB122 – Practice of Naturopathy

Dear Representative Olson:

The Alaska State Medical Association (ASMA) represents physicians statewide and is primarily concerned with the health of all Alaskans.

Thank you for the opportunity to testify on HB122.

ASMA opposes HB122 and any expansion of a naturopath's scope of practice beyond that which is currently formed in AS08.45.

Naturopaths essentially wish to have the same scope of practice as Primary Care Physicians (MDs and DOs). It is a difficult if not impossible task to determine if a naturopath's education and training is comparable to that of an MD or a DO. ASMA questions that the naturopaths' education and training have comparable depth and breadth as that of an MD or DO.

It is extremely difficult, if not impossible, to compare U.S. medical schools with those from the rest of the world that educate a large number of physicians now practicing in America.

The Alaska State Medical Board (SMB) is a member of a federation of all states' licensing and disciplinary boards, the Federation of State Medical Boards (FSMB). FSMB's journal, "The Journal of Medical License and Discipline," contained, in an edition (Volume 94, Number 3, 2008), an interesting article by David Alan Johnson, M.A., Vice President for Assessment Services – FSMB. The title of the article is "Prospects for a National Clearinghouse on International Medical Schools." It contains an interesting proposal that identifies a way to establish a clearinghouse that contains quality indicators for international medical schools.

There are about 1,800 international medical schools and currently international medical graduates (IMGs) compose 25% of the U.S. physician workforce. According to Mr. Johnson the contribution of the U.S. licensed IMGs is considerable and data exist that they are more likely to practice in medically underserved areas than U.S. graduates. The FSMB has been dealing with trying to assess qualifications of the international medical schools for many years, reported in articles in its journals dating to 1916, according to Johnson. He states the challenge remains the same, "...how to assess the qualifications of physicians graduated from non-U.S. medical schools despite possessing limited information (at best) as to the educational curriculum of these schools...". However, he also stated that only 10 of these international schools contributed 60% of the IMGs in the U.S. from 1998 through 2002.

The approach for the clearinghouse includes data and information that serve as patent safety indicators. Those indicators as put forth by Mr. Johnson are as follows:

- "admission requirements, including mandatory tests such as the MCAT;
- the number of years the medical school program has been in operation
- school policies related to providing advance standing for students entering from related health professions;
- the degree to which distance learning is utilized in the curriculum; the number of weeks of instruction – both classroom and clinical – culminating in a medical degree;
- the status of the school as it appears in other review processes involving licensure (e.g., the Medical Board of California review process), clinical clerkships (New York state's clerkship approval list) and eligibility for federal student loans (National Commission on Foreign Medical Education and Accreditation);
- aggregate United States Medical Licensing Examination performance data for students and/or graduates of the school;
- student progression rates toward successful completion of degree requirements;
- the school's success rate in placing students in Accreditation Council for Graduating Medical Education or AOA-approved residency programs; and
- information on clinical clerkships, such as whether these are performed outside the host country where the school is located or if an affiliation agreement exists with the hospital(s) where clerkships are being conducted."

This approach is one of developing a "proxy" methodology short of an in-depth, ongoing review of each of the 10 international medical schools, which is not feasible as it obviously would not be for 1,800 such schools. This is a methodology that could be termed "The proof of the pudding is in the tasting."

ASMA does not believe that the Legislature has now, and is unlikely to have in the future, the objective information that would enable it to make the major patient-safety policy decision it is being asked to make in HB122.

One document, in the supporting documents, is titled "Training Hours for Various Healthcare Professional Programs." It is an example of a suboptimal comparison of the education and training differences. To begin with, it is curious that HB122's proponents did not use local comparisons. It would seem that the advance nurse practitioner data should have been from the University of Alaska's program; and that the data for the MD should have come from the University of Washington Medical School, home for the WWAMI program (and perennially one of the top ranked schools for primary care physician education). However, most importantly, there is no data pertaining to the residency training.

It is in the residency training where the physician really learns all aspects of patient care, with hands-on experience in both the outpatient and inpatient (in hospital) settings. Attached is a comparison produced by the American Academy of Family Physicians that includes hours for the required residency in family medicine. AAFP compares its required 3-year residency program for a Family Physician to the 1-year optional residency program for naturopaths. As you can see, the hours, respectively, are 9,000 to 10,000 versus 535 to1,035.

ASMA would suggest that if you need more information about Family Medicine residency programs that you contact Harold Johnston, MD, who heads Alaska's own Family Medicine residency program.

Parenthetically, for any IMG to be licensed in Alaska, that candidate must have successfully completed a minimum of a 3-year residency program accredited by the Accreditation Council for Graduate Medical Education for MDs and an American Osteopath Association (AOA) for DOs.

Recently (February 18, 2011) Alaska's Department of Health and Social Services released a bulletin with news that Alaska has now placed near the bottom in rates of childhood immunizations, based on a national survey done by the U.S. Centers for Disease Control and Prevention (CDC). Alaska is 49th among all states, with a rate of immunizations of 56.6% compared with the national average of 70.5%. A University of Washington study reported in 2009 in the Maternal and Child Health Journal ("Pediatrics Vaccination and Vaccine Preventable Disease Acquisition: Associations with Care by Complementary and Alternative Medicine Providers," Volume 14, Number 6, 922-930, DOI: 10.1007/s10995-009-0519-5): "Children were significantly less likely to receive each of the four recommended vaccinations if they saw a naturopathic physician." Furthermore, it stated that "Children aged 1-17 years were significantly more likely to be diagnosed with vaccine preventable disease if they received naturopathic care." It would seem that if the naturopathic standard of care for children does not include recommendations for parents to have their kids vaccinated for preventative illnesses, there is a gap in their knowledge base. Are there other gaps in naturopaths' standard of care for children?

Section 15 of HB122 would add naturopathic service as an optional coverage for Medicaid. Testimony at the 2/28/11 House Labor and Commerce Committee hearing from the naturopathic community indicated such coverage was advantageous to help alleviate a problem of lack of access to care for Medicaid beneficiaries. ASMA is not aware of any problems with access to primary care for Medicaid beneficiaries. That is not the case for the federal Medicare program, for which naturopaths are not recognized providers. (For the record, the Medicaid program in Alaska compensates physicians much better than the Medicare program.) However, Section 15 raises several other questions that need to be addressed:

1. What would the "naturopathic services" be that would be proposed to be covered under Medicaid?
2. What would be the cost to Medicaid program for such services?; and
3. How would those services be paid, as no CPT codes exist specifically for naturopaths – not only for Medicaid but for other payors as well?

Another question raised by Section 15, but unrelated to the Medicaid program, is would HB122 provide for coverage for "naturopathic services" under Workers Compensation in Alaska?

Section 13 also provides for some issues that you need to address. First, it would create for confusion for the general public. This section would allow a naturopath to call him or herself a "naturopathic doctor of medicine," "naturopathic MD," naturopathic DO," "naturopathic doctor of osteopathic medicine," or "naturopathic physician." Additionally, a search of the Alaska statutes produces over 200 references for the term "physician." What are consequences for Section 13 throughout the Alaska code? The potential for unintentional consequences is great, and all those references need to be examined for to determine if other problems are created.

ASMA will oppose bills such as HB122 that expand the scope of practice for naturopaths beyond what is currently allowed in AS 08.45 until:

1. The U.S. and Canadian schools of naturopathy that grant doctoral degrees are accredited by the same accrediting bodies for the U.S. and Canadian medical schools: the Liaison Committee on Medical Education (LCME) or the American Osteopathic Association (AOA), Commission on Osteopathic College Accreditation (COCA);

2. All candidates for admission to U.S. and Canadian schools of naturopathy are required to take the Medical College Admission Test (MCAT);

3. All graduates of U.S. and Canadian schools of naturopathy pass all three steps/levels of the United States Medical Licensing Examination (USMLE) or the Comprehensive Osteopathic Medical Examination (COMLEX – USA), using the same passing criteria as the MDs or DOs, respectively;

4. All naturopaths seeking licensure must successfully complete at least a three-year residency program that is accredited by the same accrediting body, Accreditation Council for Graduate Medical Education (ACGME), for MDs and AOA-approved residency programs for DOs;

5. All naturopaths are subject to the same standard of care criteria as MDs and DOs for licensing sanction actions and in litigation, including allegations of malpractice;

6. All naturopaths are required to report to the state the outcome of each malpractice or action for which damages have been or are to be paid, whether by judgment or settlement; and

7. The state reports all actions against a naturopath to the National Practitioner Data Bank.

Such requirements are appropriate to protect the public.

ASMA feels that patient safety and public health trump all other considerations – even workforce shortages. Additionally, ASMA feels that the Legislature in evaluating HB122 and other issues involving scope of practice needs to adopt the judiciary's highest standard of proof – that the extension of the increased scope of practice beyond a reasonable doubt will provide for the public's safety.

ASMA urges you to oppose HB122 and any other measures to expand the naturopaths' scope of practice beyond that which currently exists in AS08.45.

Sincerely

By: Carl Rosen, MD, President
For: The Alaska State Medical Association

cc: Representative Craig Johnson
Representative Mike Chenault
Representative Dan Saddler
Representative Steve Thompson
Representative Lindsey Holmes
Representative Bob Miller

AAFP

Education and Training:
Family Physicians versus Naturopaths

Naturopaths—also known as "Doctors of Naturopathy," "Doctors of Natural Medicine," "Naturopathic Physicians," and the like—receive their education typically through a four-year degree program that confers a Doctorate in Naturopathy (ND) or Doctorate in Naturopathic Medicine (NMD). Currently, there are four institutions in the United States— Bastyr University, National College of Natural Medicine, Southwest College of Naturopathic Medicine, and the University of Bridgeport—accredited by the Council on Naturopathic Medical Education (CNME), the only accrediting organization recognized by the US Department of Education. Naturopathic medicine schools do not require students to satisfactorily pass an entrance exam, such as the Medical College Admissions Test (MCAT) or Graduate Record Examination (GRE). CNME requires the course of study provided at these institutions be at 4,100 total clock hours in length.

This figure includes clinical education clock hours beginning in the third year of naturopathic study. At least 1,200 clinical clock hours are required, 60 percent of which (720) hours must be in direct patient care. Graduates of naturopathic degree programs are not required to undergo post-graduate training, like the residency required of medical school graduates. Optional 1 year programs are offered by some institutions. The University of Bridgeport, for example, offers a program that includes from 535 to 1,035 total hours of direct patient contact and didactic learning.

Family Physicians receive their education typically through a four-year degree program at one of the 130 accredited medical schools in the United States. Students must pass the Medical College Admissions Test for entrance into medical school. In 2005, the average score of matriculants was 30.2 of a possible 45. Medical students spend nearly 9,000 hours in lectures, clinical study, lab and direct patient care. The overall training process begins with medical school and continues through residency. During their time in medical school, students take two "step" exams, called the United States Medical Licensing Examination (USMLE), and must take core clerkships, or periods of clinical instruction. Passing both exams and the clerkships grants students the Medical Doctor (MD) degree, which entitles them to start full clinical training in a residency program.

Family medicine residency programs, which are accredited by the Accreditation Council for Graduate Medical Education (ACGME), require three years of training. As with other specialties, family medicine residency programs have specific requirements with certain numbers of hours that must be completed for board certification. They are designed to provide integrated experiences in ambulatory, community and inpatient environments during three years of concentrated study and hands-on training.

The first year of residency, called the internship year, is when the final "step" of the USMLE (Step 3 exam) is taken. During their three years of training, residents must meet the program requirements for both residency education in family medicine and certification by the American Board of Family Medicine (ABFM). Specific requirements for family medicine residency training vary by program. After three "program years" of training are completed and all requirements are met, residents are eligible to take the certification exam by the ABFM. Toward the end of residency, physicians also apply for licensure from their state medical boards, which determines where they can practice as a board-certified family physician. Although each state is different in their requirements for initial medical licensure, it is a necessity that physicians pass Step 3 of the USMLE.

The below tables offer a side-by-side comparison of the education and training involved in becoming a family physician versus the requirements to become a naturopath.

Degrees Required and Time to Completion

	Undergraduate Degree	Entrance Exam	School	Residency	Residency Completion Time
Family Physician (MD or DO)	Standard 4-year BA/BS	Medical College Admissions Test (MCAT)	4 years	REQUIRED	3 years
Naturopath (ND or NMD)	Standard 4-year BA/BS	None Required	4 years	OPTIONAL	1 year

Medical/Professional School and Residency/Post-Graduate Hours for Completion

	Lecture Hours (Pre-Clinical Years)	Study Hours (Pre-Clinical Years)	Combined** Hours (Clinical Years)	Residency Hours	TOTAL HOURS
Family Physician	2,700	3,000	6,000	9,000 – 10,000	20,700 – 21,700
Naturopath***	1,500	1,665	2,600	535 – 1,035	5,505 – 6,485
DIFFERENCE	1,200	1,335	3,400	8,465 – 8,965	15,195 – 15,215

*Council on Naturopathic Medical Education CNME standards were used for this comparison.
**Clinical and lecture hours
***Naturopath "Lecture Hours" and "Combined Hours" are averaged across publicly-available curricula advertised on the web sites of the four CNME-accredited institutions of naturopathic study (Bastyr University, National College of Natural Medicine, Southwest College of Naturopathic Medicine, and the University of Bridgeport).

Drafted by Greg Martin, Manager, State Government Affairs, AAFP

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).*

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

Cal. App. 2003 Patient and her husband sued medical clinic for terminating care after the patient filed malpractice claims against two clinic physicians. Clinic's policy required termination of all medical care for patients and their families in such a situation. Appeals court upheld summary judgment for the clinic on several claims, but denied summary judgment on claims for interference with contractual relations, negligent infliction of emotional distress, and breach of fiduciary duty. Quotes Principles VI and VIII. *Scripps Clinic v. Superior Court, 108 Cal. App.4th 917, 134 Cal. Rptr. 2d 101,, 117.*

Ohio 2009 Physician appealed from a judgment affirming an order of the State Medical Board that permanently revoked appellant's certificate to practice medicine. The Board found that appellant's sexual contact with patients violated Ohio statutes governing physician conduct and the Code of Ethics of the AMA, citing Principles I, II, IV, and VIII. The Court of Appeals held that Ohio state law allows the Board to revoke a physician's certificate if it finds that the person violated any provision of the Code of Ethics of the AMA. *D'Souza v. State Med. Bd. of Ohio, 2009 WL 5108774, 6.*

Journal 2009 Explores emerging issues in conflict management systems design (CMSD). Concludes as the practice of CMSD in the organizational context continues to expand, practitioners should openly discuss the emerging issues of the field. References Principles I, II, V, and VIII. Costantino, *Second Generation Organizational Conflict Management Systems Design: A Practitioner's Perspective on Emerging Issues, 14 Harv. Negot. L. Rev. 81, 95 (2009).*

Journal 2009 Examines therapeutic uses of cannabis and the legal and social controversies surrounding its legalization. Concludes changes in the regulation of medical cannabis are necessary to better care for patients and better utilize resources that are currently directed toward the war on drugs. Quotes Principle VIII and Opinion 2.17. DiFonzo, *The End of the Red Queen's Race: Medical Marijuana in the New Century, 27 Quinnipiac L. Rev. 673, 736, 737 (2009).*

Journal 2009 Discusses the interaction between statutes and case law governing the medical field and the core principles of medical professionalism. Concludes the legal framework of medical professionalism does not encompass all the elements required of a medical professional. Quotes Principles II, III, IV, V, VI, VII, and VIII. Fichter, *The Law of Doctoring: A Study of the Codification of Medical Professionalism, 19 Health Matrix 317, 338, 339, 340, 343, 351 (2009).*

Journal 2009 Discusses the importance of trust in the physician-patient and in the attorney-client relationship. Notes the lack of an appropriate remedy for breaches of fiduciary duties. Concludes there should be a statutory remedy for breaches of trust in the professional relationship. Quotes Principle VIII. Forell & Sortun, *The Tort of Betrayal of Trust, 42 U. Mich. J. L. Reform, 557, 603 (2009).*

Journal 2009 Explores the jurisprudential foundation of the fiduciary duty physicians owe their patients and discusses the failure of physicians to disclose to patients errors and other emergent medical risks. Concludes law should recognize the physician's duty to disclose such risks by enforcing a cause of action for breach of that duty. Quotes Principles III and VIII and Opinions 8.12, 10.015, and 10.02. References Opinion 8.12. Hafemeister, *Lean on Me: A Physician's Fiduciary Duty to Disclose an Emergent Medical Risk to the Patient, 86 Wash. U. L. Rev. 1167, 1172-1173, 1178, 1182, 1185, 1188, 1209 (2009).*

Journal 2009 Explores the nature of the physician-patient relationship and the impact of increased availability of medical information on patient autonomy and physician responsibility to exercise independent judgment. Concludes physicians must treat patients in accordance with their fiduciary obligation to use their own judgment when confronted with a patient demanding unnecessary medical services. Quotes Preamble, Principles I and VIII, and Opinions 2.035, 8.03 and 10.015. Hafemeister, *The Fiduciary Obligation of Physicians to "Just Say No" If an "Informed" Patient Demands Services That Are Not Medically Indicated, 39 Seton Hall L. Rev. 335, 372, 373, 374 (2009).*

Journal 2009 Discusses whether or not patients have a right to pain management. Concludes that no physician duty is established by law or ethics to provide pain management outside the traditional physician-patient relationship. Cites Principles I, II, IV, and VIII. Hall & Boswell, *Ethics, Law, and Pain Management as a Patient Right, 12 Pain Physician 499, 500 (2009).*

Journal 2008 Discusses ex parte interviews with a treating physician in discovery before and after the HIPAA Privacy Rule and the issues facing physicians contacted for such interviews. Concludes courts and attorneys should work together to allow for efficient discovery while protecting physicians. Quotes Principles IV and VIII and Opinions 5.05 and 10.01. Burnette & Morning, *HIPAA and Ex Parte Interviews—the Beginning of the End? 1 J. Health & Life Sci. L. 73, 100-01 (2008).*

Journal 2008 Discusses legal and ethical considerations in making organ transplants available to qualified incarcerated individuals at public expense. Concludes legal and ethical norms suggest organ transplants should be made available to prisoners and new policies should be established to provide necessary transplant services. Apparent reference to Principle VIII. McKinney, Winslade, & Stone, *Offender Organ Transplants: Law, Ethics, Economics, and Health Policy, 9 Hous. J. Health L. & Pol'y 39, 62 (2008).*

Journal 2008 Discusses covenants not to compete and Kentucky cases dealing with physician noncompetition agreements. Concludes Kentucky should enact legislation permitting reasonable noncompetition agreements ancillary to sale of practice contracts to increase patient choice of physician. Quotes Principle VIII and Opinion 9.02. Naiser, *Physician Noncompetition Agreements in Kentucky: The Past Discounting of Public Interests and a Proposed Solution, 47 U. Louisville L. Rev. 195, 195, 200 (2008).*

Journal 2008 Examines the development of bioethics and environmental ethics, as well as laws promoting the role of bioethicists in decision making. Concludes environmental ethicists must convince legislatures of the role of environmental ethics in order to have a greater impact on decision making. Quotes Principles I, II, III, IV, V, VI, VII, VIII, and IX. Robertson, *Seeking a Seat at the Table: Has Law Left Environmental Ethics Behind as it Embraces Bioethics?, 32 Wm. & Mary Envtl. L. & Pol'y Rev. 273, 307 (2008).*

Journal 2008 Examines ethical issues related to broadcasting cardiothoracic surgeries for educational and media purposes. Concludes that seven ethical guidelines should be followed to ensure patient safety. Quotes Principle VIII and Opinion 8.121. Sade, *Broadcast of Surgical Procedures as a Teaching Instrument in Cardiothoracic Surgery, 86 Ann. Thorac. Surg. 357, 359 (2008).*

Journal 2008 Argues that as a matter of public health, physicians must control antibiotic administration to combat antibiotic resistance. Concludes that despite limited incentives for antibiotic conservation, physicians must acknowledge their important role in mitigating the public health threat of antibiotic resistance. Quotes Principles VII and VIII and Opinions 2.09 and 10.015. Cites Opinion 2.03. Saver, *In Tepid Defense of Population Health: Physicians and Antibiotic Resistance, 34 Am. J. L. & Med. 431, 457 (2008).*

Journal 2008 Explores the fiduciary relationship between physicians and patients, professional and ethical obligations of both physicians and lawyers, and the implications for conflict resolution in health care. Concludes physicians must put patient interests above their own and lawyers must work to discern clients' best interests and support client welfare. Quotes Principle VIII and Opinions 8.12 and 10.015. Cites Principles I and II and Opinions 10.01 and 10.015. Scott, *Doctors as Advocates, Lawyers as Healers, 29 Hamline J. Pub. L. Pol'y, 331, 340-41, 347, 371 (2008).*

Journal 2007 Compares the role of conscience clauses in various professions. Concludes that conscience clauses in the area of health care must not impede access to care. Quotes Preamble and Principles V, VI, and VIII. Chudoba, *Conscience in America: The Slippery Slope of Mixing Morality with Medicine, 36 Sw. U. L. Rev. 85, 86, 103, 104, 105 (2007).*

Journal 2007 Addresses physician liability for an extramarital affair with a patient's spouse. Concludes that such an affair should be regarded as a breach of a fiduciary duty. Quotes Preamble, Principles I, II, and VIII, and Opinions 8.145, 9.04, 9.123, and 10.015. Demaine, *'Playing Doctor' With the Patient's Spouse: Alternative Conceptions of Health Professional Liability, 14 Va. J. Soc. Pol'y & L. 308, 325, 330-31, 331-32 (2007).*

Journal 2007 Discusses the evolution of informed consent doctrine. Concludes that, in context of research, informed consent exceptions should be substantially narrowed. Quotes Ch. I, Art. I,

Sec. 4 (May 1847) [now Opinion 8.082] and Ch. I, Art. I, Sec. 1 (May 1847) [now Principles I and VIII]. References Opinions 2.08 and 8.08. Grimm, *Informed Consent for All! No Exceptions, 37 N. M. L. Rev. 39, 39, 61 (2007).*

Journal 2007 Analyzes drafters'original intent for the Confrontation Clause as well as the contemporary interpretation under Crawford. Concludes that only statements taken by law enforcement agents should be considered testimonial in nature. Quotes Principle VIII. Harbinson, *Crawford v. Washington and Davis v. Washington's Originalism: Historical Arguments Showing Child Abuse Victims' Statements to Physicians are Nontestimonial and Admissible as an Exception to the Confrontation Clause, 58 Mercer L. Rev. 569, 617 (2007).*

Journal 2007 Evaluates the added cost of extrarenal findings in CT imaging of kidney donors. Concludes that because incidental findings arise in 28% of cases, pertinent ethical issues should be considered. References Principle VIII. Maizlin, Barnard, Gourlayz, & Brown, *Economic and Ethical Impact of Extrarenal Findings on Potential Living Kidney Donor Assessment with Computed Tomography Angiography, 20 Transplant Int'l. 338, 341 (2007).*

Journal 2006 Evaluates the constitutionality of federal Faith-Based Initiative programs. Concludes that such programs violate the First Amendment under the combined Lemon and Zelman test. Cites Principles II and VIII. Boden, *Compassion Inaction: Why President Bush's Faith-Based Initiatives Violate the Establishment Clause, 29 Seattle U. L. Rev. 991, 1023 (2006).*

Journal 2006 Examines ethical dilemmas physicians may face as providers of pay-for-performance medical care. Concludes that this strategy offers a benefit to patients as long as physicians uphold stringent ethical standards and work together to ensure optimum patient care. Cites Principles I, V, VIII, and IX and Opinions 2.035, 2.095, 6.01, 8.021, 8.03, 8.0501, 8.053, 8.054, and 8.121. Bostick, Sade & McMahon, *Report of the Council on Ethical and Judicial Affairs: Physician Pay-For-Performance Programs, 3 Ind. Health L. Rev. 429, 430, 431, 432-33, 434, 435, 436 (2006).*

Journal 2006 Examines the legal and public health issues raised by increased rates of Hepatitis C in prison populations. Concludes that reform is needed to provide adequate health care to prisoners and that courts have the power to require such care under the Eighth Amendment. Quotes Preamble, Principles VII, VIII, and IX, and Opinion 10.015. Brunsden, *Hepatitis C in Prisons: Evolving Toward Decency Through Adequate Medical Care and Public Health Reform, 54 UCLA L. Rev. 465, 500 (2006).*

Journal 2006 Explores conscience clause legislation relating to the dispensing of oral contraceptives. Concludes that such legislation must balance the interests of the patient and the health care provider. Cites Principles I, II, III, IV, V, VI, VII, VIII, and IX. Collins, *Conscience Clauses and Oral Contraceptives: Conscientious Objection or Calculated Obstruction?, 15 Ann. Health L. 37, 54 (2006).*

Journal 2006 Discusses mentally incompetent inmates and capital punishment. Proposes that, to be permissible, involuntary medication of death-row inmates must represent the best medically appropriate treatment. Quotes Principles I, III, and VIII and Opinion 2.06. Gabos, *The Perils of Singleton v. Norris: Ethics and Beyond, 32 Am. J. L. & Med. 117, 118, 125-26, 127 (2006).*

Journal 2006 Examines the practice of law firms employing their own in-house counsel. Concludes there will likely be an increase in firms that retain in-house counsel to represent them. Quotes Principle VIII. Gorman, *Empirical Studies of the Legal Profession: What do We Know About Lawyers' Lives?: Explaining the Spread of Law Firm In-House Counsel Positions: A Response to Professor Chambliss. 84 N. C. L. Rev. 1577, 1585.*

Journal 2006 Discusses the prevalence and cause of physicians' failure to provide proper care. Concludes that patients should be able to sue their physicians for breach of fiduciary duty. Quotes Principle VIII and Opinion 8.03. Mehlman, *Dishonest Medical Mistakes, 59 Vand. L. Rev. 1137, 1144 (2006).*

Journal 2006 Examines a mental health professional's competing duties of confidentiality and reporting a patient's threats of violence. Suggests new legislation should clarify duty to report a threat. Quotes Preamble and Principles III, IV, and VIII. Cites Opinion 5.05. Mossman, *Critique of Pure Risk Assessment or, Kant Meets Tarasoff, 75 U. Cin. L. Rev. 523, 579 (2006).*

Journal 2006 Examines the constitutionality of conscience clauses under the Fourteenth Amendment. Concludes that state involvement through the enactment of such clauses may violate the Fourteenth Amendment. Cites Principle VIII. Rozenek, *Whose Conscience Is It Anyway?*

The State's Role in Conscience Clause Creation and the Denial of Contraception, 40 Suffolk U. L. Rev. 215, 220 (2006).

Journal 2006 Reviews conflicts which arise when a physician must choose between violating a law and adhering to an ethical principle. Concludes the physician must consider the needs of the patient and acknowledges that there are cases where violating a law may be justified. Quotes Principle VIII and Opinion 1.02. Schwartz, *The Ethical Health Lawyer: When Doing the Right Thing Means Breaking the Law - What is the Role of the Health Lawyer?, 34 J. L. Med. & Ethics 624, 625, 626 (2006).*

Journal 2005 Discusses physician responses to the medical malpractice liability crisis. Concludes that certain responses may violate ethical obligations that physicians owe to their patients and to society as a whole. Cites Opinions 9.025 and 10.015. References Principle VIII. Kachalia, Choudhry, & Studdert, *Physician Responses to the Malpractice Crisis: From Defense to Offense, 33 J. L. Med. & Ethics 416, 419, 421, 424 (2005).*

Journal 2005 Argues that the Eighth Circuit's ruling in *Singleton v. Norris* failed to consider the ethical standards of the medical community. Concludes that, as a result, physicians may be placed in an untenable position regarding treatment of mentally ill death-row inmates. Quotes Principle VIII and Opinions 1.02 and 2.06. Lloyd, *Primum Non Nocere: Singleton v. Norris and the Ethical Dilemma of Medicating the Condemned, 58 Ark. L. Rev. 225, 232, 233 (2005).*

Journal 2005 Examines issues surrounding tort reform proposals. Concludes that more can be done to correct the current tort system before moving toward a "one size fits all" approach. Quotes Principles I, II, III, IV, V, VI, VII, VIII, and IX. Messerly & Warwick, *Nowhere to Turn: A Glance at the Facts Behind the Supposed Need for Tort "Reform," 28 Hamline L. Rev. 489, 506 (2005).*

Journal 2005 Argues that in *Aetna v. Davila/Cigna v. Calad*, the Supreme Court missed an opportunity to overturn unjust ERISA policies. Concludes that the principle of complete ERISA preemption as articulated in these consolidated cases is unsatisfactory because it violates the separation of powers doctrine. Quotes Principle VIII. Cites Opinions 8.054, 8.13, 8.135, 9.123, 10.01, and 10.015. Nelson, *AETNA v. DAVILA/CIGNA v. CALAD: A Missed Opportunity, 31 Wm. Mitchell L. Rev. 843, 847, 849, 850, 880 (2005).*

Journal 2004 Examines the requirements of the Privacy Rule regarding use and disclosure of a patient's identifiable health information in the context of research. Concludes that the Rule's burdensome administrative requirements may discourage research and thus outweigh any benefits for research subject autonomy. Quotes Principle VIII and Opinions 5.051, 8.031, and 10.015. Tovino, *The Use and Disclosure of Protected Health Information for Research Under the HIPAA Privacy Rule: Unrealized Patient Autonomy and Burdensome Government Regulation, 49 S. D. L. Rev. 447, 496, 502 (2004).*

Journal 2003 Examines social norms, using public choice theory, to determine how certain groups in society use these norms to benefit their members. Concludes that the benefits provided by social norms may dissipate depending on various considerations. Quotes Principles II and VIII. Miller, *Norms and Interests, 32 Hofstra L. Rev. 637, 650, 670 (2003).*

Journal 2002 Examines how managed care has adversely affected information disclosure in the physician-patient relationship. Concludes that, unless courts expand applicability of principles of informed consent, patient self-determination and autonomy will continue to be undermined. Quotes Principle VIII and Opinions 8.03, 8.053, 8.054, and 8.08. Morris, *Dissing Disclosure: Just What the Doctor Ordered, 44 Ariz. L. Rev. 313, 344, 349, 362, 363, 366 (2002).*

Journal 2002 Considers the dilemma of informed consent in the context of prescribing psychotropic medication to patients with mental illness and mental retardation. Recognizes the need for substituted decision-making in certain situations. Concludes that legislation would help address this issue. Quotes Preamble, Principles I, III, IV, VIII, and IX, and Opinion 8.08. O'Sullivan & Borcherding, *Informed Consent for Medication in Persons with Mental Retardation and Mental Illness, 12 Health Matrix 63, 75, 86, 87, 88 (2002)*

Journal 2002 Discusses legal and medical policies that protect confidentiality in the physician-patient relationship. Concludes that reducing the current level of privacy protection would jeopardize health care. Quotes Preamble and Opinions 2.136, 5.05, and 10.01. References Principles VIII and IX. Sciarrino, *Ferguson v. City of Charleston: "The Doctor Will See You Now,*

Be Sure to Bring Your Privacy Rights in With You!" 12 Temp. Pol. & Civ. Rts. L. Rev. 197, 213, 215, 220, 221, 222 (2002).

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

Journal 2008 Examines the development of bioethics and environmental ethics, as well as laws promoting the role of bioethicists in decision making. Concludes environmental ethicists must convince legislatures of the role of environmental ethics in order to have a greater impact on decision making. Quotes Principles I, II, III, IV, V, VI, VII, VIII, and IX. Robertson, *Seeking a Seat at the Table: Has Law Left Environmental Ethics Behind as it Embraces Bioethics?, 32 Wm. & Mary Envtl. L. & Pol'y Rev. 273, 307 (2008).*

Journal 2006 Examines ethical dilemmas physicians may face as providers of pay-for-performance medical care. Concludes that this strategy offers a benefit to patients as long as physicians uphold stringent ethical standards and work together to ensure optimum patient care. Cites Principles I, V, VIII, and IX and Opinions 2.035, 2.095, 6.01, 8.021, 8.03, 8.0501, 8.053, 8.054, and 8.121. Bostick, Sade & McMahon, *Report of the Council on Ethical and Judicial Affairs: Physician Pay-For-Performance Programs, 3 Ind. Health L. Rev. 429, 430, 431, 432-33, 434, 435, 436 (2006).*

Journal 2006 Examines the legal and public health issues raised by increased rates of Hepatitis C in prison populations. Concludes that reform is needed to provide adequate health care to prisoners and that courts have the power to require such care under the Eighth Amendment. Quotes Preamble, Principles VII, VIII, and IX, and Opinion 10.015. Brunsden, *Hepatitis C in Prisons: Evolving Toward Decency Through Adequate Medical Care and Public Health Reform, 54 UCLA L. Rev. 465, 500 (2006).*

Journal 2006 Explores the legal and ethical issues surrounding concierge medicine. Concludes that concierge medicine is best restricted to a small class of wealthy individuals. Quotes Principle IX and Opinion 8.055. Cites Principle VI and Opinions 8.055, 8.11, 8.115, 9.065, and 10.05. Carnahan, *Law, Medicine, and Wealth: Does Concierge Medicine Promote Health Care Choice, or is it a Barrier to Access?, 17 Stan. L. & Pol'y Rev. 121, 149-50, 151, 152, 153-54 (2006).*

Journal 2006 Explores conscience clause legislation relating to the dispensing of oral contraceptives. Concludes that such legislation must balance the interests of the patient and the health care provider. Cites Principles I, II, III, IV, V, VI, VII, VIII, and IX. Collins, *Conscience Clauses and Oral Contraceptives: Conscientious Objection or Calculated Obstruction?, 15 Ann. Health L. 37, 54 (2006).*

Journal 2006 Considers the interaction of laws, rules, and guidelines in the area of health law. Suggests that the legislature should revise current laws to reflect local variability in practice. Quotes Preamble and Principles VII and IX. Heimer, *Responsibility in Health Care: Spanning the Boundary Between Law and Medicine, 41 Wake Forest L. Rev. 465, 498 (2006).*

Journal 2006 Discusses the role of EMTALA in mandating care for the uninsured. Concludes EMTALA is inadequate and Congress should take steps toward establishing a program for universal health care. Quotes Principle IX and Ch. II, Art. V, Sec. 9 (May 1847) [now Opinion 9.065] and Ch. III, Art. I, Sec. 3 (May 1847) [now Opinion 9.065]. Hermer, *The Scapegoat: EMTALA and Emergency Department Overcrowding, 14 J. L. & Pol'y 695, 713-14 (2006).*

Journal 2005 Discusses legal and ethical problems associated with patient surcharges. Concludes that surcharges are necessary to combat rising malpractice insurance premiums and a declining payment environment. Cites Principle IX and Opinion 6.12. Landfair, *Transforming Physicians into Business Savvy Entrepreneurs: Patient Surcharges Charge onto the Scene of Physician Reimbursement, 43 Duq. L. Rev. 257, 268, 269 (2005).*

Journal 2005 Examines issues surrounding tort reform proposals. Concludes that more can be done to correct the current tort system before moving toward a "one size fits all" approach. Quotes Principles I, II, III, IV, V, VI, VII, VIII, and IX. Messerly & Warwick, *Nowhere to Turn: A Glance at the Facts Behind the Supposed Need for Tort "Reform," 28 Hamline L. Rev. 489, 506 (2005).*

Journal 2005 Examines the practice of "boutique medicine" and considers legal and ethical implications. Concludes that boutique medical services would be ethical only if physicians used retainer money from their boutique clients to augment health care costs of the poor. Quotes Principles VII and IX and Opinion 8.055. Russano, *Is Boutique Medicine a New Threat to American*

10.00 Opinions on the Patient-Physician Relationship

10.01 Fundamental Elements of the Patient-Physician Relationship

From ancient times, physicians have recognized that the health and well-being of patients depends upon a collaborative effort between physician and patient. Patients share with physicians the responsibility for their own health care. The patient-physician relationship is of greatest benefit to patients when they bring medical problems to the attention of their physicians in a timely fashion, provide information about their medical condition to the best of their ability, and work with their physicians in a mutually respectful alliance. Physicians can best contribute to this alliance by serving as their patients' advocate and by fostering these rights:

(1) The patient has the right to receive information from physicians and to discuss the benefits, risks, and costs of appropriate treatment alternatives. Patients should receive guidance from their physicians as to the optimal course of action. Patients are also entitled to obtain copies or summaries of their medical records, to have their questions answered, to be advised of potential conflicts of interest that their physicians might have, and to receive independent professional opinions.

(2) The patient has the right to make decisions regarding the health care that is recommended by his or her physician. Accordingly, patients may accept or refuse any recommended medical treatment.

(3) The patient has the right to courtesy, respect, dignity, responsiveness, and timely attention to his or her needs.

(4) The patient has the right to confidentiality. The physician should not reveal confidential communications or information without the consent of the patient, unless provided for by law or by the need to protect the welfare of the individual or the public interest.

(5) The patient has the right to continuity of health care. The physician has an obligation to cooperate in the coordination of medically indicated care with other health care providers treating the patient. The physician may not discontinue treatment of a patient as long as further treatment is medically indicated, without giving the patient reasonable assistance and sufficient opportunity to make alternative arrangements for care.

(6) The patient has a basic right to have available adequate health care. Physicians, along with the rest of society, should continue to work toward this goal. Fulfillment of this right is dependent on society providing resources so that no patient is deprived of necessary care because of an inability to pay for the care. Physicians should continue their traditional assumption of a part of the responsibility for the medical care of those who

cannot afford essential health care. Physicians should advocate for patients in dealing with third parties when appropriate. (I, IV, V, VIII, IX)

Issued June 1992 based on the report "Fundamental Elements of the Patient-Physician Relationship," adopted June 1990 (*JAMA*. 1990;262:3133). Updated 1993.

Colo. App. 1999 Physician filed suit seeking reinstatement, compensatory damages, and an opportunity to respond to the reasons for termination. The defendants claimed that the contract with the physician provided for termination without cause. The trial court granted the defendants' motion for summary judgment. The appellate court affirmed, holding that the termination clause allowed either party to terminate the contract without cause. In a separate dissenting opinion, judge stated that termination without cause significantly impacts the physician-patient relationship and referenced Fundamental Elements (5) [now Opinion 10.01], regarding the continuity of this relationship. *Grossman v. Columbine Medical Group, Inc., 1999 WL 1024015, 4-5.*

Ga. App. 2000 Plaintiff alleged failure on the part of a dentist to inform him of the risks of root canal in a malpractice action. The appeals court noted that state case law did not recognize the informed consent doctrine. In evaluating this precedent, the court quoted Opinion 8.08 and Fundamental Element (1) [now Opinion 10.01]. The court stated that the AMA Code of Medical Ethics should be understood to reflect the standard of care of the medical profession on the issue of informed consent. While the court ruled in favor of the dentist, it prospectively recognized the doctrine of informed consent. *Ketchup v. Howard, 247 Ga. App. 54, 543 S.E.2d 371, 376, 377.*

Ill. 2006 Physicians appealed a grant of preliminary injunction enforcing restrictive covenants in their employment contracts. Quoting Opinions 9.02, 9.06, and 10.01 and referencing Opinion 8.115, the Illinois Supreme Court gave thorough consideration to the AMA's position on restrictive covenants. While acknowledging the ethical problems associated with such contracts, the court found the covenants reasonable in scope. The decision to ban restrictive covenants, the court reasoned, was best left to the legislature. *Mohanty v. St. John Heart Clinic, S.C., 225 Ill.2d 52, 866 N.E.2d 85, 94, 106-07, 107-08.*

N.Y. Fam. 2006 During proceedings regarding a foster child, an issue was raised contesting the legality of the County Department of Human Services' procedures for administering drugs to children. The mother's consent for prescribing medication to the child was obtained by a caseworker, without direct consultation with a physician and with no explanation of side effects. The court cited Opinions 8.08, 8.081, 8.11, and 10.01 in determining the physician's duty to honor the decision of the parent/surrogate. The mother's consent was invalidated and she was given an opportunity to consult with a physician. *Matter of Lyle A., 14 Misc. 3d 842, 830 N.Y.S.2d 486,492,494.*

Tenn. App. 1998 Plaintiff challenged the constitutionality of various sections of state abortion statute. Among the provisions at issue was one requiring that a woman be "orally informed by her attending physician" as to specified information regarding the abortion. The court stated that the information requirement and physician counseling provision did not unduly burden a woman's right to an abortion. Physicians who supported this portion of the statute quoted Fundamental Element (1) [now Opinion 10.01], regarding a physician's duty to counsel a patient about the best treatments available. *Planned Parenthood of Middle Tennessee v. Sundquist, 1998 WL 467110, 33.*

Wis. App. 2007 Plaintiff brought action for medical abandonment against his physician. The physician had cancelled an elective surgery and terminated the relationship with the patient after the plaintiff sued the surgical center employing the physician. The circuit court granted summary judgment for the physician finding plaintiff's claim unsupported by expert testimony. With apparent reference to Opinions 8.115 and 10.01, the plaintiff argued that AMA ethics opinions supported his claim. The appeals court held, however, that expert testimony was required to prove the appropriate standard of care. *Casperson v. N.E. Wis. Ctr. for Surgery & Rehab of Hand, Ltd., 2007 WL 1191782, 3.*

Journal 2009 Discusses the judicial standard for reviewing physician noncompete covenants. Concludes courts should apply a strict standard to such covenants, rather than declare the covenants per se invalid. Quotes Principles IV and VII, Principles of Medical Ethics §5 (1957) [now Principle VI], Code of Medical Ethics Ch. II, Art. I §3 (1847) [now Opinion 5.02], Opinion 9.02, and Code of Medical Ethics Ch. II, Art. I §4 (1847) [now Opinion 9.09]. Cites Opinions 8.041, 8.115, 9.02, 9.06, 9.065, 9.067, 10.01, and 10.015. Koons, *Physician Employee Non-Compete*

Agreements on the Examining Table: The Need to Better Protect Patients' and the Public's Interests in Indiana, 6 *Ind. Health L. Rev. 253, 272-77, 280-81 (2009).*

Journal 2008 Discusses ex parte interviews with a treating physician in discovery before and after the HIPAA Privacy Rule and the issues facing physicians contacted for such interviews. Concludes courts and attorneys should work together to allow for efficient discovery while protecting physicians. Quotes Principles IV and VIII and Opinions 5.05 and 10.01. Burnette & Morning, *HIPAA and Ex Parte Interviews—the Beginning of the End? 1 J. Health & Life Sci. L. 73, 100-01 (2008).*

Journal 2008 Reviews the obligation of a physician to provide a referral for the termination of a pregnancy, when the treating physician objects to the procedure on ethical grounds. Concludes that the physician has an ethical duty to inform the patient of other providers who can offer competent care. Cites Opinion 10.01. Chervenak & McCullough, *The Ethics of Direct and Indirect Referral for Termination of Pregnancy, 199 Am. J. Obstet. Gynecol. 232.e1, 232.e1 (2008).*

Journal 2008 Considers the utility of physician apologies for medical error and legal protection for physicians who apologize for mistakes. Concludes physicians must openly communicate with their patients and apologize for medical errors to strengthen the health care community. Quotes Opinions 8.08, 8.12, 10.01, and 10.015. References Opinion 8.12. Ebert, *Attorneys, Tell Your Clients to Say They're Sorry: Apologies in the Health Care Industry, 5 Ind. Health L. Rev. 337, 340-41, 344 (2008).*

Journal 2008 Explores the fiduciary relationship between physicians and patients, professional and ethical obligations of both physicians and lawyers, and the implications for conflict resolution in health care. Concludes physicians must put patient interests above their own and lawyers must work to discern clients' best interests and support client welfare. Quotes Principle VIII and Opinions 8.12 and 10.015. Cites Principles I and II and Opinions 10.01 and 10.015. Scott, *Doctors as Advocates, Lawyers as Healers, 29 Hamline J. Pub. L. Pol'y, 331, 340-41, 347, 371 (2008).*

Journal 2007 Reviews Deborah Rhode's analysis of pro bono obligations of lawyers from her book, *Pro Bono in Principle and in Practice: Public Service and the Professions*. Concludes that a mandatory pro bono requirement is a better solution than an incentive-based system. Quotes Principle 10.01. Lininger, *From Park Place to Community Chest: Rethinking Lawyers' Monopoly, 101 Nw. U. L. Rev. 1343, 1349 (2007).*

Journal 2007 Considers relevant policy issues surrounding prenatal torts. Concludes that North Carolina should allow bringing of claims for prenatal, postconception malpractice. Quotes Opinion 10.01. McEntire, *Compensating Post-Conception Prenatal Medical Malpractice While Respecting Life: A Recommendation to North Carolina Legislators, 29 Campbell L. Rev. 761, 763 (2007).*

Journal 2006 Analyzes cases where a patient's right to refuse care conflicts with the physician's obligation to protect that patient's well-being. Concludes health care providers should seek a compromise that best promotes both patient autonomy and well-being. Quotes Principle IV and Ch. I, Art. II, Sec. 6 (May 1847) [now Opinion 10.01]. Carrese, *Refusal of Care: Patients' Well-being and Physicians' Ethical Obligations, 296 JAMA 691, 692, 693 (2006).*

Journal 2006 Reviews informed consent doctrine in the context of consumer-driven health care. Concludes that consumer-driven health care should not be undermined by arguments about patient competence to make health care decisions. References Opinion 10.01. Kapp, *Patient Autonomy in the Age of Consumer-Driven Health Care: Informed Consent and Informed Choice, 2 J. Health & Biomedical L. 1, 5 (2006).*

Journal 2005 Discusses standard of care issues surrounding physicians using complementary and alternative medicine (CAM). Concludes that a prudent physician standard should apply to physicians practicing CAM. Quotes Opinion 10.01. Cites Opinion 10.02. Kallmyer, *A Chimera in Every Sense: Standard of Care for Physicians Practicing Complementary and Alternative Medicine, 2 Ind. Health L. Rev. 225, 229, 231 (2005).*

Journal 2005 Argues that in *Aetna v. Davila/Cigna v. Calad*, the Supreme Court missed an opportunity to overturn unjust ERISA policies. Concludes that the principle of complete ERISA preemption as articulated in these consolidated cases is unsatisfactory because it violates the separation of powers doctrine. Quotes Principle VIII. Cites Opinions 8.054, 8.13, 8.135, 9.123, 10.01, and 10.015. Nelson, *AETNA v. DAVILA/CIGNA v. CALAD: A Missed Opportunity, 31 Wm. Mitchell L. Rev. 843, 847, 849, 850, 880 (2005).*

Journal 2005 Discusses ethical, legal, and policy issues associated with treatment and research involving patients who are in a persistent vegetative or minimally conscious state. Concludes that patients in these states are at risk for therapeutic failures until physicians can more accurately determine which patients will benefit from treatment and accurately convey such information to families or surrogates. Quotes Principles VII and IX and Opinions 8.031, 8.0315, 9.065, 10.01, and 10.015. Tovino & Winslade, *A Primer on the Law and Ethics of Treatment, Research, and Public Policy in the Context of Severe Traumatic Brain Injury, 14 Ann. Health L. 1, 18, 38, 39, 40, 41 (2005).*

Journal 2004 Discusses medical errors in various health care settings and offers an ethical framework to support immediate implementation of proposed solutions. Concludes that federal and state legislators must place priority on developing policies that will help reduce the number of medical errors. Quotes 10.01. Clark, *Medication Errors in Family Practice, in Hospitals and After Discharge from the Hospital: An Ethical Analysis, 32 J. L. Med & Ethics 349, 354 (2004).*

Journal 2004 Analyzes Maryland's Drug Addiction at Birth Act, which was passed to help health care professionals deal with drug-exposed infants. Concludes that more effective legislation could be enacted to educate health care providers regarding treatment of infants with prenatal drug exposure. Quotes Opinion 10.01. Reese & Burry, *Evaluating Maryland's Response to Drug-Exposed Babies, 10 Psychol. Pub. Pol'y & L. 343, 353 (2004).*

Journal 2003 Reviews state laws designed to protect physicians acting as patient advocates in managed care organizations. Concludes that federal and state law must make it easier for physicians to challenge denials of or delays in patient care. Quotes Opinions 8.054, 8.13, and 10.01. Fentiman, *Patient Advocacy and Termination from Managed Care Organizations. Do State Laws Protecting Health Care Professional Advocacy Make Any Difference?, 82 Neb. L. Rev. 508, 515-16, 517-18 (2003).*

Journal 2003 Highlights the legal and ethical concerns surrounding use of noncompetition clauses. Concludes that physicians should carefully evaluate these clauses given their likely enforceability. Quotes Opinions 9.02, 9.06, 10.01, and 10.015. Loeser, *The Legal, Ethical, and Practical Implications of Noncompetition Clauses: What Physicians Should Know Before They Sign, 31 J. L. Med. & Ethics 283, 286, 287, 290 (2003).*

Journal 2003 Considers the legal, medical, and ethical issues of physician-patient confidentiality in disclosure of paternity. Concludes that a balancing test should be applied to making determinations regarding disclosure of paternity. Quotes Principles I, IV, and V and Opinions 1.02, 5.055, and 10.01. Cites Principle II and Opinion 5.05. Richards & Wolf, *Medical Confidentiality and Disclosure of Paternity, 48 S. D. L. Rev. 409, 411, 412, 413 (2003).*

Journal 2003 Evaluates medical necessity decisions in managed care, with emphasis on therapeutic effectiveness. Concludes that, in order to be effective, review procedures and policies governing medical necessity determinations must be improved. Quotes Opinion 10.01. Sage, *Managed Care's Crimea: Medical Necessity, Therapeutic Benefit, and the Goals of Administrative Process in Health Insurance, 53 Duke L. J. 597, 634 (2003).*

Journal 2003 Argues that affirmative measures should be taken by the Air Force to ensure access to abortion services. Concludes that regulatory changes will reduce barriers to access. Quotes Opinion 10.01. Cites Opinion 8.08. Wilde, *Air Force Women's Access to Abortion Services and the Erosion of 10 USC § 1093, 9 Wm. & Mary J. Women & L. 351, 371 (2003).*

Journal 2003 Discusses potential liability of mental health care providers who administer court-ordered treatment to patients. Concludes that providers should treat these patients as much like voluntary patients as possible. References Opinion 10.01. Wilde, *The Liability of Alaska Mental Health Providers for Mandated Treatment, 20 Alaska L. Rev. 271, 276 (2003).*

Journal 2002 Argues for a more comprehensive approach in the management and treatment of intersex children. Emphasizes the importance of informed decision-making by parents and children. Quotes Opinion 10.01. Hermer, *Paradigms Revised: Intersex Children, Bioethics & the Law, 11 Annals Health L. 195, 221 (2002).*

Journal 2002 Discusses issues regarding regulation of elderly drivers. Concludes that mandating physicians to report unfit elderly patients will protect the public and help resolve ethical and legal dilemmas. Quotes Opinions 1.02, 2.24, 5.05, and 10.01. Kane, *Driving into the Sunset: A Proposal for Mandatory Reporting to the DMV by Physicians Treating Unsafe Elderly Drivers, 25 U. Haw. L. Rev. 59, 59, 61, 62, 67, 69, 82, 83 (2002).*

Journal 2002 Reviews how changes in the health care delivery system underscore the importance of information in patient empowerment. Concludes that patients should use information to take charge of their health care. Quotes Principle V and Opinion 10.02. Cites Opinion 10.01. Kane, *Information is the Key to Patient Empowerment, 11 Annals Health L. 25, 29-30, 44 (2002).*

Journal 2002 Considers the ethical and legal issues regarding breach of confidentiality in situations where a patient is pregnant and uses teratogenic substances. Concludes that a breach of confidentiality causes damage to the physician-patient relationship. Quotes Principle IV and Opinion 10.01. Plambeck, *Divided Loyalties: Legal and Bioethical Considerations of Physician-Pregnant Patient Confidentiality and Prenatal Drug Abuse, 23 J. Legal Med. 1, 8, 25 (2002).*

Journal 2002 Analyzes the role of prognostication in physician-patient communication. Concludes that the patient-physician model of shared decision-making offers the best hope for reestablishing prognostication. Quotes Principles Ch. I, Art. I, Sec. 2 and 4 (1846) [now Principle IV and Opinions 8.12 and 10.01]. Cites Opinion 8.08. Rich, *Prognostication in Clinical Medicine: Prophecy or Professional Responsibility?, 23 J. Legal Med. 297, 299, 318, 327 (2002).*

Journal 2002 Discusses legal and medical policies that protect confidentiality in the physician-patient relationship. Concludes that reducing the current level of privacy protection would jeopardize health care. Quotes Preamble and Opinions 2.136, 5.05, and 10.01. References Principles VIII and IX. Sciarrino, *Ferguson v. City of Charleston: "The Doctor Will See You Now, Be Sure to Bring Your Privacy Rights in With You!" 12 Temp. Pol. & Civ. Rts. L. Rev. 197, 213, 215, 220, 221, 222 (2002).*

Journal 2001 Explores the ethical and legal dilemmas associated with doctors and lawyers providing advice over the Internet. Concludes the law must ensure that cyberprofessionals comply with ethical and legal duties to their clients and their professions. Quotes Opinion 10.01. Deady, *Cyberadvice: The Ethical Implications of Giving Professional Advice over the Internet, 14 Geo. J. Legal Ethics 891, 905 (2001).*

Journal 2001 Discusses whether or not the medical profession needs a policy on honesty. Reviews ethical codes and concludes they fail to offer physicians with meaningful guidance about what constitutes "the truth" and when and how to disclose it. Quotes Principle II and Opinions 8.12 and 10.01. DeVita, *Honestly, Do We Need a Policy on Truth?, 11 Kennedy Inst. Ethics J. 157, 158 (2001).*

Journal 2001 Discusses issues surrounding the privacy of genetic information. Considers the social, ethical, and legal responses to problems that arise in this context. Concludes with a unique view of privacy that would protect the right of individuals not to know genetic information about themselves. Quotes Principle IV and Opinion 10.01. Laurie, *Challenging Medical-Legal Norms: The Role of Autonomy, Confidentiality, and Privacy in Protecting Individual and Familial Group Rights in Genetic Information, 22 J. Legal Med. 1, 24 (2001).*

Journal 2001 Considers conflicts of interest in clinical research and other types of medical practice. Compares the way in which doctors and lawyers address conflicts of interest in professional practice. Concludes that physicians are unaware of the need to create a meaningful conflict-of-interest doctrine for medical practice. Quotes Preamble, Principle IV, and Opinions 2.07, 8.03, 8.031, and 10.01. Moore, *What Doctors Can Learn from Lawyers about Conflicts of Interest, 81 B. U. L. Rev. 445, 447, 449-50 (2001).*

Journal 2001 Compares ongoing efforts to control reproduction and to control drug abuse with a view toward finding more effective solutions in both areas. Concludes that a coherent approach will build stronger coalitions in support of drug policy reform and reproductive freedom. Quotes Opinion 10.01. Paltrow, *The War on Drugs and the War on Abortion: Some Initial Thoughts on the Connections, Intersections and the Effects, 28 S.U. L. Rev. 201, 219 (2001).*

Journal 2001 Considers how much information regarding the adverse effects of medication physicians should disclose to patients. Concludes that most patients want complete information. Quotes Opinion 10.01. Ziegler, Mosier, Buenaver, & Okuyemi, *How Much Information About Adverse Effects of Medication Do Patients Want From Physicians?, 161 Arch. Intern. Med. 706, 710 (2001).*

Journal 2000 Introduces the debate surrounding the benefits and dangers of diagnosing and treating patients over the Internet and explores the issue of how cybermedicine will change the traditional physician-patient relationship. Concludes cybermedicine is the future of medical care, and the physician-patient relationship will have to change to accommodate the predicted online

medical boom. Quotes Opinion 10.01. Gelein, *Are Online Consultations a Prescription for Trouble? The Uncharted Waters of Cybermedicine, 66 Brook. L. Rev. 209, 239 (2000).*

Journal 2000 Discusses patent law and policy. Examines whether or not those who practice medicine should be excused from patent laws because of the conflict that medical procedure patents create with respect to the practice of medicine. Concludes that Congress should repeal section 287(c) of the Patent Act. Quotes Principle V and Opinions 9.08 and 9.09. Cites Opinion 8.03. References Opinion 10.01. Ho, *Patents, Patients, and Public Policy: An Incomplete Intersection at 35 USC § 287(c), 33 U.C. Davis L. Rev. 601, 603, 623, 624, 625, 631 (2000).*

Journal 2000 Describes the fiduciary aspects of the physician-patient relationship. Explores the conflicts that may occur between physicians and pregnant women in the health care setting. Proposes legal strategies to address these conflicts. Quotes Opinions 8.08 and 10.01. References Opinion 8.13. Oberman, *Mothers and Doctors' Orders: Unmasking the Doctor's Fiduciary Role in Maternal-Fetal Conflicts, 94 Nw. U. L. Rev. 451, 456, 462, 493 (2000).*

Journal 2000 Evaluates recent Texas legislation that affords immunity to health care professionals who provide free health care services to the poor. Concludes that such legislation creates a dual standard of care, requiring indigent patients to forfeit their legal rights in exchange for health care. Quotes Opinion 10.01. References Opinion 9.065. Pulido, *Immunity of Volunteer Health Care Providers in Texas: Bartering Legal Rights for Free Medical Care, 2 Scholar: St. Mary's L. Rev. Minority Issues 323, 330 (2000).*

Journal 2000 Considers the topic of physician liability for genetic malpractice. Explores how new genetic technologies may affect the medical and legal communities. Concludes by observing that the legal system is not prepared to address the wave of litigation that may grow out of emerging genetic technologies. Quotes Opinion 10.01. Reutenauer, *Medical Malpractice Liability in the Era of Genetic Susceptibility Testing, 19 QLR 539, 571 (2000).*

Journal 2000 Discusses managed care in terms of problems, responses, and accomplishments. Demonstrates how a physician union's collective bargaining process can benefit patients and physicians in addressing problems with managed care. Concludes that barriers preventing such unions should be removed. Quotes Principles VI and VII and Opinion 10.01. Rugg, *An Old Solution to a New Problem: Physician Unions Take the Edge Off Managed Care, 34 Colum. J. L. & Soc. Probs. 1, 41 (2000).*

Journal 2000 Examines ethical and legal issues regarding medical privacy. Discusses authorized and unauthorized uses of information contained in medical records and identifies who may access these records. Analyzes the ethical balance between patient privacy and societal benefits derived from sacrificing it. Concludes privacy is very important to maintaining a full and open physician-patient relationship. Quotes Opinion 10.01. Scott, *Is Too Much Privacy Bad for Your Health? An Introduction to the Law, Ethics, and HIPAA Rule on Medical Privacy, 17 Ga. St. U. L. Rev. 481, 494 (2000).*

Journal 2000 Discusses the development and history of the ethical doctrine of informed consent. Examines the current state of the law in Pennsylvania and concludes it does not adequately fulfill the goals of ethical and legal doctrines. Quotes Principle IV and Opinion 10.01. References Opinion 8.08. Warren, *Pennsylvania Medical Informed Consent Law: A Call to Protect Patient Autonomy Rights By Abandoning the Battery Approach, 38 Duq. L. Rev. 917, 925 (2000).*

Journal 1999 Examines reporting of AIDS and HIV under Texas law. Discusses limitations on a physician's ability to warn potentially at-risk third parties. Concludes that Texas law should be changed to place a duty upon physicians to notify at-risk third parties of a patient's HIV-positive status. Quotes Principle IV and Opinion 10.01. Acosta, *The Texas Communicable Disease Prevention and Control Act: Are We Offering Enough Protection to Those Who Need It Most?, 36 Hous. L. Rev. 1819, 1822, 1830, 1831 (1999).*

Journal 1999 Discusses the need for physicians to advocate on behalf of patients' rights in the context of health care delivery. Evaluates the nature and scope of the physician's role as advocate, noting that physicians cannot be expected to engage in attorney-like advocacy. Quotes Principles IV and VI, Fundamental Elements (2), (4), and (6) [now Opinion 10.01], Patient Responsibilities 5 [now Opinion 10.02], and Opinions 2.03, 2.07, 2.09, 2.16, 2.19, 3.06, 4.01, 4.04, 6.01, 7.02, 8.02, 8.03, 8.13, 8.132, 9.06, 9.07, and 9.131. Cites Opinions 5.05, 5.09, 7.01, 8.135, and 9.02. Sage, *Physicians as Advocates, 35 Hous. L. Rev. 1529, 1537, 1541, 1542, 1552-53, 1554, 1556, 1557, 1559, 1561-62, 1564, 1571, 1574, 1576, 1580 (1999).*

Journal 1998 Discusses conflicts of interest in the physician-patient relationship arising out of use of financial incentives by managed care organizations. Considers how such conflicts are dealt with in the attorney-client relationship. Suggests that a financial incentive should be legally denounced if it unreasonably interferes with a physician's duty to properly care for and treat patients. Quotes Preamble, Fundamental Elements (1) [now Opinion 10.01], and Opinions 4.04, 5.01, 8.03, 8.13, and 9.06. Cites Fundamental Elements (4) [now Opinion 10.01] and Opinions 2.07, 2.08, and 2.132. Hall, *Third-Party Payor Conflicts of Interest in Managed Care: A Proposal for Regulation Based on the Model Rules of Professional Conduct, 29 Seton Hall L. Rev. 95, 96, 107, 108, 109, 110, 111, 112, 134, 135, 136 (1998).*

Journal 1997 Compares past ethical opinions to current opinions and notes the differences. Comments on the forces that have changed medical ethics through the years. Notes differing theories on the future course of medical ethics. Quotes Fundamental Elements (Preamble) and Opinions 5.05, 5.057, 7.01, 8.12, 9.12, and 9.131. Cites Fundamental Elements (5) and Opinions 8.115 and 8.13. Buchanan, *Medical Ethics at the Millennium: A Brief Retrospective, 26 Colo. Law. 141, 142, 143, 144, 145 (1997).*

Journal 1997 Reviews ethical issues raised by genetic research. Explores the duty a physician may have to reveal the genetic diseases found in patients to their relatives. Considers case law and statutory law, and concludes that a limited duty to disclose exists. Quotes Fundamental Elements (4). Deftos, *Genomic Torts: The Law of the Future—The Duty of Physicians to Disclose the Presence of a Genetic Disease to the Relatives of Their Patients with the Disease, 32 USF. L. Rev. 105, 130 (1997).*

Journal 1997 Discusses physician frustration with managed care plans caused by gag clauses and cost-containment mechanisms. Reviews the development of managed care organizations and federal attempts at limiting the use of gag clauses. Concludes that gag clauses are inherently flawed and compromise quality health care. Quotes Principles II and V, Fundamental Elements (1), and Opinion 8.13. Note, *Physicians, Bound and Gagged: Federal Attempts to Combat Managed Care's Use of Gag Clauses, 21 Seton Hall Legis. J. 567, 601-02 (1997).*

Journal 1997 Considers the current approach to health care in the US. Examines financing mechanisms, and suggests that reform could be effected through a decentralized, community-based approach. Proposes use of volunteer systems in which medical personnel would care for certain patients free of charge or at reduced rates. Quotes Fundamental Elements (6). References Opinion 9.065. Solomon & Asaro, *Community-Based Health Care: A Legal and Policy Analysis, 24 Fordham Urb. L. J. 235, 276-77 (1997).*

Journal 1996 Describes the problem of lack of access to medical care by the indigent. Recognizes the commitment of the medical profession to providing care for indigent patients. Observes that state initiatives that provide physicians tort immunity in exchange for volunteer service can improve access to care by the indigent. Quotes Fundamental Elements (6). References Opinion 9.065. Comment, *Statutory Immunity for Volunteer Physicians: A Vehicle for Reaffirmation of the Doctor's Beneficent Duties—Absent the Rights Talk, 1 Widener L. Symp. J. 425, 448, 449 (1996).*

Journal 1996 Considers the ethical requirement for physicians to receive informed consent from patients before beginning treatment. Reviews the case of *Jacobson v. Massachusetts*, discussing its impact on informed consent and vaccination policy in the US. Quotes Fundamental Elements (2). References Opinion 8.08. Severyn, *Jacobson v. Massachusetts: Impact on Informed Consent and Vaccine Policy, 5 J. Pharmacy & L. 249, 253, 274 (1996).*

Journal 1996 Examines medically futile treatment in light of legislative enactments in Virginia and Maryland. Observes that the futility debate arises when requests for life-prolonging treatment are viewed as medically inappropriate by health care providers. Concludes that, while the ethical integrity of the medical profession justifies some legal recognition of futility, such recognition must be limited by respect for patient autonomy. References Fundamental Elements (5). Shiner, *Medical Futility: A Futile Concept?, 53 Wash. & Lee L. Rev. 803, 834 (1996).*

Journal 1995 Examines the impact of health care reform on physician-patient relationships. Discusses how reform may threaten the physician's fiduciary duty of loyalty by forcing physicians to make rationing decisions and giving physicians financial incentives to limit use of health care resources. Quotes Fundamental Elements (5) [now Opinion 10.01]. Cites Opinion 5.05. Orentlicher, *Health Care Reform and the Patient-Physician Relationship, 5 Health Matrix 141, 143, 148 (1995).*

Journal 1994 Considers whether an exception should be made to physician-patient confidentiality that would allow a physician to reveal parental medical history to a child. Concludes that such an exception would not completely erode physician-patient confidentiality. Quotes Principles IV, Fundamental Elements (4), and Opinion 5.05. Cites Principle I and Fundamental Elements (1). Friedland, *Physician-Patient Confidentiality: Time to Re-Examine a Venerable Concept in Light of Contemporary Society and Advances in Medicine, 15 J. Legal Med. 249, 257, 264, 276 (1994).*

Journal 1994 Explores the ethical issues involved in a multidisciplinary team working with children in legal proceedings. Focuses on the relationships between professionals and the conflicts that arise regarding disclosure of confidential information and forced disclosure of nonprivileged information. Quotes Principles III and IV, Fundamental Elements (4), and Opinions 1.02 (1992) and 5.07 (1992) [now Opinion 5.05]. Cites Opinions 2.02. Glynn, *Multidisciplinary Representation of Children: Conflicts Over Disclosures of Client Communications, 27 J. Marshall L. Rev. 617, 625, 626, 630-32, 637, 639, 643 (1994).*

Journal 1994 Discusses physician-patient confidentiality and the exception that permits breach of a patient's confidence if required by law. Argues that this is always a legitimate exception to the confidentiality rule. Quotes Principle IV and Fundamental Elements (4). McConnell, *Confidentiality and the Law, 20 J. Med. Ethics 47, 47 (1994).*

Journal 1994 Reviews the evolution of the physician-patient relationship, with attention to the changing health care delivery environment. Quotes Preamble, Principles I, II, III, IV, V, and VI, Fundamental Elements (1) and (2), and Opinions 1.02 and 8.07 (1981) [now Opinion 8.08]. Cites Opinion 1.01. Szczygiel, *Beyond Informed Consent, 21 Ohio N. U. L. Rev. 171, 217, 218, 220, 225, 226, 256 (1994).*

Journal 1994 Discusses the importance of confidentiality in the physician-patient relationship and under what circumstances patient information may be released. Examines unique considerations that apply when a physician provides medical care to a minor or an HIV-infected individual. Quotes Principle IV and Fundamental Elements (4). Weiner & Wettstein, *Confidentiality of Patient-Related Information, 112 Arch. Ophthalmology 1032, 1033 (1994).*

Journal 1993 Analyzes the implications of giving patients and their families an absolute right to control medical treatment. Argues that courts should refrain from ordering physicians to treat patients when physicians believe that treatment would be ineffective. Quotes Fundamental Elements (5) [now Opinion 10.01] and Opinions 2.11 (1982) [now Opinion 2.20] and 2.18 (1986) [now Opinion 2.20]. Comment, *Beyond Autonomy: Judicial Restraint and the Legal Limits Necessary to Uphold the Hippocratic Tradition and Preserve the Ethical Integrity of the Medical Profession, 9 J. Contemp. Health L. & Pol'y 451, 467, 468 (1993).*

10.015 The Patient-Physician Relationship

The practice of medicine, and its embodiment in the clinical encounter between a patient and a physician, is fundamentally a moral activity that arises from the imperative to care for patients and to alleviate suffering.

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

The relationship between patient and physician is based on trust and gives rise to physicians' ethical obligations to place patients' welfare above their own self-interest and above obligations to other groups, and to advocate for their patients' welfare.

Within the patient-physician relationship, a physician is ethically required to use sound medical judgment, holding the best interests of the patient as paramount. (I, II, VI, VIII)

Issued December 2001 based on the report "The Patient-Physician Relationship," adopted June 2001.

Army Crim. App. 2004 Appellant, in a general court martial hearing, was found guilty of unpremeditated murder. The Court of Appeals for the Armed Forces set aside and remanded the judgment to the Army Court of Criminal Appeals to determine whether there was a conflict of interest in allowing mental health providers who had a prior psychotherapist-patient relationship with the appellant to serve on his sanity board. The court determined there was no conflict of interest. In making this determination, the court quoted Opinion 10.015 and cited Opinion 8.03 to analyze the aspects of the physician-patient relationship. *United States v. Best, 59 M.J. 886, 891 n. 8.*

Minn. App. 2005 Minnesota Board of Medical Practice revoked the license of appellant, finding that appellant carried on an inappropriate sexual relationship with a patient. Quoting Opinion 10.015, the appeals court determined that the individual whom the appellant was treating fell within the definition of patient, and therefore, appellant's sexual relationship with the patient was a violation of the Minnesota Medical Practice Act, justifying the revocation of his license. *In re Woolley, 2005 WL 2077475, 6.*

Journal 2009 Considers a physician's role in educating patients about health care reform. Concludes that reform would be aided by educating patients on all aspects of the health care system. Quotes Opinion 10.015. Cites Opinion 9.012. Abemayor, *United We Stand, Divided We Fall, 135 Arch. Otolaryngol. Head Neck Surg. 432, 432, 433 (2009).*

Journal 2009 Explores the jurisprudential foundation of the fiduciary duty physicians owe their patients and discusses the failure of physicians to disclose to patients errors and other emergent medical risks. Concludes law should recognize the physician's duty to disclose such risks by enforcing a cause of action for breach of that duty. Quotes Principles III and VIII and Opinions 8.12, 10.015, and 10.02. References Opinion 8.12. Hafemeister, *Lean on Me: A Physician's Fiduciary Duty to Disclose an Emergent Medical Risk to the Patient, 86 Wash. U. L. Rev. 1167, 1172-1173, 1178, 1182, 1185, 1188, 1209 (2009).*

Journal 2009 Explores the nature of the physician-patient relationship and the impact of increased availability of medical information on patient autonomy and physician responsibility to exercise independent judgment. Concludes physicians must treat patients in accordance with their fiduciary obligation to use their own judgment when confronted with a patient demanding unnecessary medical services. Quotes Preamble, Principles I and VIII, and Opinions 2.035, 8.03 and 10.015. Hafemeister, *The Fiduciary Obligation of Physicians to "Just Say No" If an "Informed" Patient Demands Services That Are Not Medically Indicated, 39 Seton Hall L. Rev. 335, 372, 373, 374 (2009).*

Journal 2009 Discusses the judicial standard for reviewing physician noncompete covenants. Concludes courts should apply a strict standard to such covenants, rather than declare the covenants per se invalid. Quotes Principles IV and VII, Principles of Medical Ethics §5 (1957) [now Principle VI], Code of Medical Ethics Ch. II, Art. I §3 (1847) [now Opinion 5.02], Opinion 9.02, and Code of Medical Ethics Ch. II, Art. I §4 (1847) [now Opinion 9.09]. Cites Opinions 8.041, 8.115, 9.02, 9.06, 9.065, 9.067, 10.01, and 10.015. Koons, *Physician Employee Non-Compete Agreements on the Examining Table: The Need to Better Protect Patients' and the Public's Interests in Indiana, 6 Ind. Health L. Rev. 253, 272-77, 280-81 (2009).*

Journal 2008 Considers the utility of physician apologies for medical error and legal protection for physicians who apologize for mistakes. Concludes physicians must openly communicate with their patients and apologize for medical errors to strengthen the health care community. Quotes Opinions 8.08, 8.12, 10.01, and 10.015. References Opinion 8.12. Ebert, *Attorneys, Tell Your Clients to Say They're Sorry: Apologies in the Health Care Industry, 5 Ind. Health L. Rev. 337, 340-41, 344 (2008).*

Journal 2008 Studies the likelihood and causes of physicians discharging patients. Concludes that physicians should be educated about the ethical and legal consequences of discharging patients for reasons other than dangerous or illegal behavior. References Opinion 10.015. Farber, Jordan, Silverstein, Collier, Weiner, & Boyer, *Primary Care Physicians' Decisions About Discharging Patients from Their Practices, 23 J. of General Internal Med. 283, 283 (2008).*

Journal 2008 Discusses FDA advisory opinion preempting failure-to-warn claims brought against pharmaceutical companies and examines ethical problems throughout pharmaceutical industry. Concludes that litigation is an important check on the industry, encouraging quality research

and safe medications. Quotes Opinion 10.015. Martin, *Hugs and Drugs: Research Ethics, Conflict of Interest, and Why the FDA's Attempt to Preempt Pharma Failure-to-Warn Claims is a Dangerous Prescription*, 6 *Ave Maria L. Rev. 587, 621 (2008).*

Journal 2008 Examines the medical malpractice system and the reasons why patients sue. Argues that lack of effective communication between physician and patient is the underlying cause of litigation. Concludes voluntary mediation of claims may decrease medical malpractice litigation if attorneys, health professionals, and the federal government encourage use of mediation. Quotes Opinion 10.015. Meruelo, *The Need to Understand Why Patients Sue and a Proposal for a Specific Model of Mediation*, 29 *J. Legal Med. 285, 290 (2008).*

Journal 2008 Argues that as a matter of public health, physicians must control antibiotic administration to combat antibiotic resistance. Concludes that despite limited incentives for antibiotic conservation, physicians must acknowledge their important role in mitigating the public health threat of antibiotic resistance. Quotes Principles VII and VIII and Opinions 2.09 and 10.015. Cites Opinion 2.03. Saver, *In Tepid Defense of Population Health: Physicians and Antibiotic Resistance*, 34 *Am. J. L. & Med. 431, 457 (2008).*

Journal 2008 Explores the fiduciary relationship between physicians and patients, professional and ethical obligations of both physicians and lawyers, and the implications for conflict resolution in health care. Concludes physicians must put patient interests above their own and lawyers must work to discern clients' best interests and support client welfare. Quotes Principle VIII and Opinions 8.12 and 10.015. Cites Principles I and II and Opinions 10.01 and 10.015. Scott, *Doctors as Advocates, Lawyers as Healers*, 29 *Hamline J. Pub. L. Pol'y, 331, 340-41, 347, 371 (2008).*

Journal 2007 Addresses physician liability for an extramarital affair with a patient's spouse. Concludes that such an affair should be regarded as a breach of a fiduciary duty. Quotes Preamble, Principles I, II, and VIII, and Opinions 8.145, 9.04, 9.123, and 10.015. Demaine, *'Playing Doctor' With the Patient's Spouse: Alternative Conceptions of Health Professional Liability*, 14 *Va. J. Soc. Pol'y & L. 308, 325, 330-31, 331-32 (2007).*

Journal 2007 Examines the history and effectiveness of medical malpractice screening panels. Concludes that screening panels are ineffective, then proposes an alternative dispute resolution model. Quotes Opinion 10.015. Kaufman, *The Demise of Medical Malpractice Screening Panels and Alternative Solutions Based on Trust and Honesty*, 28 *J. Legal Med. 247, 250 (2007).*

Journal 2007 Discusses patients' right to refuse medical treatment and the corresponding duties of health care professionals. Concludes that detailed, carefully prepared advance directives are necessary to fulfill patients' wishes. Quotes Ch. II (1940) [Now Opinions 8.08 and 8.082] and Opinions 2.035, 2.037, 2.20, 2.225, 8.081, and 10.015. Cites Opinions 9.11 and 9.115. Stamatakis, *Beyond Advance Directives: Personal Autonomy and Their Right to Refuse Life-Sustaining Medical Treatment*, 47 *N. H. B. J. 20, 29-30 (2007).*

Journal 2006 Reviews the concept of therapeutic privilege. Concludes that the practice creates conflict between physician obligations under the concepts of autonomy and beneficence. Recommends that physicians maximize communication with patients by providing all pertinent information in the context of patient preferences. Cites Opinions 8.08, 8.081, 8.121, 10.015. References Chap. I, Art. I, Sec. 4 (May 1847) [premise deleted from Code]. Bostick, Sade, McMahon, & Benjamin, *Report of the American Medical Association Council on Ethical and Judicial Affairs: Withholding Information from Patients: Rethinking the Propriety of "Therapeutic Privilege,"* 17 *J. Clinical Ethics 302, 303 (Winter 2006).*

Journal 2006 Examines the efficacy of informed consent when a physician acts both as a researcher and care provider. Concludes that a patient cannot give truly informed consent in such cases. Cites Opinions 8.115 and 10.015. Lenrow, *The Treating Physician as Researcher: Is Assuming this Dual Role a Violation of the Nuremberg Code?*, 25 *Temp. J. Sci. Tech. & Envtl. L. 15, 42-43 (2006).*

Journal 2006 Discusses tort liability for medical malpractice. Concludes that both physicians and attorneys should support a legal system which promotes patient safety. Quotes Opinions 8.12 and 10.015. Pegalis, *A Proposal to Use Common Ground that Exists Between the Medical and Legal Professions to Promote a Culture of Safety*, 51 *N. Y. L. Sch. L. Rev. 1057, 1070, 1073 (2006).*

Journal 2006 Examines the practice by physicians of billing a malpractice surcharge. Concludes that such practice is unethical and constitutes a breach of fiduciary duty. Quotes Opinions 10.015

and 10.018. Peterson, *The Malpractice Surcharge: A Simple Answer to Rising Malpractice Rates or a Greater Threat to Quality Patient Care?*, *27 J. Legal Med. 87, 96, 97-98 (2006)*.

Journal 2006 Considers prisoners' rights to expression of sexuality and the state's legitimate interest in regulating that expression. Concludes that states should encourage healthy expressions of sexuality while protecting the goals of the Prison Rape Elimination Act. Cites Opinions 3.08, 8.14, 8.145, and 10.015. Smith, *Rethinking Prison Sex: Self-Expression and Safety, 15 Colum. J. Gender & L. 185, 202 (2006)*.

Journal 2005 Discusses physician responses to the medical malpractice liability crisis. Concludes that certain responses may violate ethical obligations that physicians owe to their patients and to society as a whole. Cites Opinions 9.025 and 10.015. References Principle VIII. Kachalia, Choudhry, & Studdert, *Physician Responses to the Malpractice Crisis: From Defense to Offense, 33 J. L. Med. & Ethics 416, 419, 421, 424 (2005)*.

Journal 2005 Argues that in *Aetna v. Davila/Cigna v. Calad*, the Supreme Court missed an opportunity to overturn unjust ERISA policies. Concludes that the principle of complete ERISA preemption as articulated in these consolidated cases is unsatisfactory because it violates the separation of powers doctrine. Quotes Principle VIII. Cites Opinions 8.054, 8.13, 8.135, 9.123, 10.01, and 10.015. Nelson, *AETNA v. DAVILA/CIGNA v. CALAD: A Missed Opportunity, 31 Wm. Mitchell L. Rev. 843, 847, 849, 850, 880 (2005)*.

Journal 2005 Discusses ethical, legal, and policy issues associated with treatment and research involving patients who are in a persistent vegetative or minimally conscious state. Concludes that patients in these states are at risk for therapeutic failures until physicians can more accurately determine which patients will benefit from treatment and accurately convey such information to families or surrogates. Quotes Principles VII and IX and Opinions 8.031, 8.0315, 9.065, 10.01, and 10.015. Tovino & Winslade, *A Primer on the Law and Ethics of Treatment, Research, and Public Policy in the Context of Severe Traumatic Brain Injury, 14 Ann. Health L. 1, 18, 38, 39, 40, 41 (2005)*.

Journal 2004 Analyzes various issues relating to the role of mental health professionals in capital punishment in light of Albert Bandura's model of "mechanisms of moral disengagement." Concludes that facilitating participation of mental health professionals in executions creates conflicts with the humanistic norms of the profession. Quotes Preamble and Opinions 1.01, 1.02, 2.06, 2.067, 2.20, 2.21, 2.211, and 8.14. Judges, *The Role of Mental Health Professionals in Capital Punishment: An Exercise in Moral Disengagement, 41 Hous. L. Rev. 515, 562, 568, 569, 570, 571-72, 581, 586, 588, 598 (2004)*.

Journal 2004 Examines the requirements of the Privacy Rule regarding use and disclosure of a patient's identifiable health information in the context of research. Concludes that the Rule's burdensome administrative requirements may discourage research and thus outweigh any benefits for research subject autonomy. Quotes Principle VIII and Opinions 5.051, 8.031, and 10.015. Tovino, *The Use and Disclosure of Protected Health Information for Research Under the HIPAA Privacy Rule: Unrealized Patient Autonomy and Burdensome Government Regulation, 49 S. D. L. Rev. 447, 496, 502 (2004)*.

Journal 2004 Addresses the problem of pediatric obesity and examines various treatment options, including gastric bypass. Concludes that, before surgery is undertaken, the best interests of the child must be prioritized, with consultative input from specialists who have no stake in the decision. Quotes 10.015. Wilde, *Bioethical and Legal Implications of Pediatric Gastric Bypass, 40 Willamette L. Rev. 575, 613 (2004)*.

Journal 2003 Highlights the legal and ethical concerns surrounding use of noncompetition clauses. Concludes that physicians should carefully evaluate these clauses given their likely enforceability. Quotes Opinions 9.02, 9.06, 10.01, and 10.015. Loeser, *The Legal, Ethical, and Practical Implications of Noncompetition Clauses: What Physicians Should Know Before They Sign, 31 J. L. Med. & Ethics 283, 286, 287, 290 (2003)*.

Journal 2002 Examines sports-related concussions among football players. Considers the responsibilities of team physicians. Concludes that litigation will increase without treatment guidelines for concussion management. References Opinion 10.015. Hecht, *Legal and Ethical Aspects of Sports-Related Concussions: The Merril Hoge Story, 12 Seton Hall J. Sport L. 17, 42-43 (2002)*.

10.016 Pediatric Decision-Making

Medical decision-making for pediatric patients should be based on the child's best interest, which is determined by weighing many factors, including effectiveness of appropriate medical therapies, the patient's psychological and emotional welfare, and the family situation. When there is legitimate inability to reach consensus about what is in the best interest of the child, the wishes of the parents should generally receive preference.

Physicians treating pediatric patients generally must obtain informed consent from a parent or a legal guardian. Certain classes of children, such as emancipated or mature minors, may provide consent to their own medical care.

Physicians should give pediatric patients the opportunity to participate in decision-making at a developmentally appropriate level. The physician should seek the patient's assent, or agreement, by explaining the medical condition, its clinical implications, and the treatment plan. If the patient does not or cannot assent, physicians should still explain the plan of care and tell him or her what to expect, without deception. In the case of an adolescent patient who has decision-making capacity, the physician should encourage the patient's active participation in decision-making. The use of force such as with using physical restraints to carry out a medical intervention in adolescent patients who do not assent should be a last resort.

Parents and physicians may disagree about the course of action that best serves the pediatric patient's interests. When disagreements occur, institutional policies for timely conflict resolution should be followed, including consultation with an ethics committee, pastoral service, or other counseling resource. If a health care facility does not have policies for resolving conflicts in a timely manner, physicians should encourage their development. Physicians should treat reversible life-threatening conditions regardless of any persistent disagreement. Resolution of disagreements in the courts should be pursued only as a last resort. (IV, VIII)

Issued June 2008 based on the report "Pediatric Decision-Making," adopted November 2007.

10.017 Gifts from Patients

Gifts that patients offer to physicians are often an expression of appreciation and gratitude or a reflection of cultural tradition, and can enhance the patient-physician relationship.

Some gifts signal psychological needs that require the physician's attention. Some patients may attempt to influence care or to secure preferential treatment through the offering of gifts or cash. Acceptance of such gifts is likely to damage the integrity of the patient-physician relationship. Physicians should make clear that gifts given to secure preferential treatment compromise their obligation to provide services in a fair manner.

There are no definitive rules to determine when a physician should or should not accept a gift. No fixed value determines the appropriateness or inappropriateness of a gift from a patient; however, the gift's value relative to the patient's or the physician's means should not be disproportionately or

inappropriately large. One criterion is whether the physician would be comfortable if acceptance of the gift were known to colleagues or the public.

Physicians should be cautious if patients discuss gifts in the context of a will. Such discussions must not influence the patient's medical care.

If, after a patient's death, a physician should learn that he or she has been bequeathed a gift, the physician should consider declining the gift if the physician believes that its acceptance would present a significant hardship (financial or emotional) to the family.

The interaction of these various factors is complex and requires the physician to consider them sensitively. (I, II)

Issued December 2003 based on the report "Gifts from Patients," adopted June 2003.

Journal 2008 Argues that organ donation from a patient to his or her physician is unethical. Concludes that this practice would be exploitative to the patient and undermine public trust in the medical profession. Cites Opinions 8.14, 10.017, and 10.018. Steinberg & Pomfret, *A Novel Boundary Issue: Should a Patient be an Organ Donor for Their Physician?, 34 J. Med. Ethics 772, 772 (2008).*

10.018 Physician Participation in Soliciting Contributions from Patients

Donations play an important role in supporting and improving a community's health care. Physicians are encouraged to participate in fundraising and other solicitation activities while protecting the integrity of the patient-physician relationship, including patient privacy and confidentiality, and ensuring that all donations are fully voluntary. In particular:

(1) Appropriate means of soliciting contributions include making information available in a reception area and speaking at fundraising events. Physicians should avoid directly soliciting their own patients, especially at the time of a clinical encounter. They should reinforce the trust that is the foundation of the patient-physician relationship by being clear that patients' welfare is the primary priority and that patients need not contribute in order to continue receiving the same quality of care.

(2) The greater the separation between the request and the clinical encounter, the more acceptable the solicitation is likely to be.

(3) When physicians participate in solicitation efforts as members of the general community, they should seek to minimize perceptions of overlap with their professional roles.

(4) Physicians in institutions that rely on fundraising personnel for donation requests should work to protect privacy and confidentiality of patient information. In particular physicians should ensure that any patient information used for solicitation activities reveals only basic demographic data, not personal health information. When the medical service delivered or the diagnosis is identifiable by the nature of the physician's practice or the physician's specialty, permission from the patient should be obtained prior to divulging any information to third parties.

(5) When patients initiate requests to contribute, physicians should refer them to appropriate sources of information or fundraising personnel.

Issued December 2004 based on the report "Physician Participation in Soliciting Contributions from Patients," adopted June 2004.

Journal 2008 Argues that organ donation from a patient to his or her physician is unethical. Concludes that this practice would be exploitative to the patient and undermine public trust in the medical profession. Cites Opinions 8.14, 10.017, and 10.018. Steinberg & Pomfret, *A Novel Boundary Issue: Should a Patient be an Organ Donor for Their Physician?*, 34 J. Med. Ethics 772, 772 (2008).

Journal 2006 Examines the practice by physicians of billing a malpractice surcharge. Concludes that such practice is unethical and constitutes a breach of fiduciary duty. Quotes Opinions 10.015 and 10.018. Peterson, *The Malpractice Surcharge: A Simple Answer to Rising Malpractice Rates or a Greater Threat to Quality Patient Care?*, 27 J. Legal Med. 87, 96, 97-98 (2006).

10.02 Patient Responsibilities

It has long been recognized that successful medical care requires an ongoing collaborative effort between patients and physicians. Physician and patient are bound in a partnership that requires both individuals to take an active role in the healing process. Such a partnership does not imply that both partners have identical responsibilities or equal power. While physicians have the responsibility to provide health care services to patients to the best of their ability, patients have the responsibility to communicate openly, to participate in decisions about the diagnostic and treatment recommendations, and to comply with the agreed-upon treatment program.

Like patients' rights, patients' responsibilities are derived from the principle of autonomy. The principle of patient autonomy holds that an individual's physical, emotional, and psychological integrity should be respected and upheld. This principle also recognizes the human capacity to self-govern and choose a course of action from among different alternative options. Autonomous, competent patients assert some control over the decisions which direct their health care. With that exercise of self-governance and free choice comes a number of responsibilities.

(1) Good communication is essential to a successful patient-physician relationship. To the extent possible, patients have a responsibility to be truthful and to express their concerns clearly to their physicians.

(2) Patients have a responsibility to provide a complete medical history, to the extent possible, including information about past illnesses, medications, hospitalizations, family history of illness, and other matters relating to present health.

(3) Patients have a responsibility to request information or clarification about their health status or treatment when they do not fully understand what has been described.

(4) Once patients and physicians agree upon the goals of therapy and a treatment plan, patients have a responsibility to cooperate with that treatment plan and to keep their agreed-upon appointments. Compliance with physician instructions is often essential to public and individual safety. Patients also have a responsibility to disclose whether previously agreed-upon treatments are being followed and to indicate when they would like to reconsider the treatment plan.

(5) Patients generally have a responsibility to meet their financial obligations with regard to medical care or to discuss financial hardships with their physicians. Patients should be cognizant of the costs associated with using a limited resource like health care and try to use medical resources judiciously.

(6) Patients should discuss end-of-life decisions with their physicians and make their wishes known. Such a discussion might also include writing an advance directive.

(7) Patients should be committed to health maintenance through health-enhancing behavior. Illness can often be prevented by a healthy lifestyle, and patients should take personal responsibility when they are able to avert the development of disease.

(8) Patients should also have an active interest in the effects of their conduct on others and refrain from behavior that unreasonably places the health of others at risk. Patients should inquire as to the means and likelihood of infectious disease transmission and act upon that information which can best prevent further transmission.

(9) Participation in medical education is to the mutual benefit of patients and the health care system. Patients are encouraged to participate in medical education by accepting care, under appropriate supervision, from medical students, residents, and other trainees. Consistent with the process of informed consent, the patient or the patient's surrogate decision maker is always free to refuse care from any member of the health care team.

(10) Patients should discuss organ donation with their physicians and, if donation is desired, make applicable provisions. Patients who are part of an organ allocation system and await needed transplant should not try to go outside of or manipulate the system. A fair system of allocation should be answered with public trust and an awareness of limited resources.

(11) Patients should not initiate or participate in fraudulent health care and should report illegal or unethical behavior by physicians and other providers to the appropriate medical societies, licensing boards, or law enforcement authorities. (I, IV, VI)

Issued June 1994 based on the report "Patient Responsibilities," adopted June 1993. Updated June 1998, December 2000, and June 2001.

Journal 2009 Explores the jurisprudential foundation of the fiduciary duty physicians owe their patients and discusses the failure of physicians to disclose to patients errors and other emergent medical risks. Concludes law should recognize the physician's duty to disclose such risks by enforcing a cause of action for breach of that duty. Quotes Principles III and VIII and Opinions 8.12, 10.015, and 10.02. References Opinion 8.12. Hafemeister, *Lean on Me: A Physician's Fiduciary Duty to Disclose an Emergent Medical Risk to the Patient, 86 Wash. U. L. Rev. 1167, 1172-1173, 1178, 1182, 1185, 1188, 1209 (2009).*

Journal 2002 Reviews how changes in the health care delivery system underscore the importance of information in patient empowerment. Concludes that patients should use information to take charge of their health care. Quotes Principle V and Opinion 10.02. Cites Opinion 10.01. Kane, *Information is the Key to Patient Empowerment, 11 Annals Health L. 25, 29-30, 44 (2002).*

Journal 2002 Discusses state regulation of health information and the Federal Health Privacy Rule, noting that it provides inadequate protection. Concludes state laws can bridge gaps in

protection. Quotes Opinion 10.02. Pritts, *Altered States: State Health Privacy Laws and the Impact of the Federal Health Privacy Rules, 2 Yale J. Health Pol'y, L. & Ethics 327, 351 (2002).*

Journal 1999 Discusses the need for physicians to advocate on behalf of patients' rights in the context of health care delivery. Evaluates the nature and scope of the physician's role as advocate, noting that physicians cannot be expected to engage in attorney-like advocacy. Quotes Principles IV and VI, Fundamental Elements (2), (4), and (6) [now Opinion 10.01], Patient Responsibilities 5 [now Opinion 10.02], and Opinions 2.03, 2.07, 2.09, 2.16, 2.19, 3.06, 4.01, 4.04, 6.01, 7.02, 8.02, 8.03, 8.13, 8.132, 9.06, 9.07, and 9.131. Cites Opinions 5.05, 5.09, 7.01, 8.135, and 9.02. Sage, *Physicians as Advocates, 35 Hous. L. Rev. 1529, 1537, 1541, 1542, 1552-53, 1554, 1556, 1557, 1559, 1561-62, 1564, 1571, 1574, 1576, 1580 (1999).*

Journal 1994 Discusses notions of quality in health care, asking who is responsible to define quality, who is responsible to deliver it, and who is responsible for quality of care when it is unsatisfactory. Concludes that significant economic changes will require a reallocation of these responsibilities among patients, providers, and payers. References Patient Responsibilities (1), (4), and (5). Morreim, *Redefining Quality by Reassigning Responsibility, 20 Am. J. Law & Med. 79, 103 (1994).*

10.03 Patient-Physician Relationship in the Context of Work-Related and Independent Medical Examinations

When a physician is responsible for performing an isolated assessment of an individual's health or disability for an employer, business, or insurer, a limited patient-physician relationship should be considered to exist. Both "industry employed physicians" (IEPs), who are employed by businesses or insurance companies for the purpose of conducting medical examinations, and "independent medical examiners" (IMEs), who are independent contractors providing medical examinations within the realm of their specialty, may perform such medical examinations.

Despite their ties to a third party, the responsibilities of IEPs and IMEs are in some basic respects very similar to those of other physicians. IEPs and IMEs have the same obligations as physicians in other contexts to:

(1) Evaluate objectively the patient's health or disability. In order to maintain objectivity, IEPs and IMEs should not be influenced by the preferences of the patient-employee, employer, or insurance company when making a diagnosis during a work-related or independent medical examination.

(2) Maintain patient confidentiality as outlined by Opinion 5.09, "Industry Employed Physicians and Independent Medical Examiners."

(3) Disclose fully potential or perceived conflicts of interest. The physician should inform the patient about the terms of the agreement between himself or herself and the third party as well as the fact that he or she is acting as an agent of that entity. This should be done at the outset of the examination, before health information is gathered from the patient-employee. Before the physician proceeds with the exam, he or she should ensure to the extent possible that the patient understands the physician's unaltered ethical obligations, as well as the differences that exist between the physician's role in this context and the physician's traditional fiduciary role.

IEPs and IMEs are responsible for administering an objective medical evaluation but not for monitoring patients' health over time, treating patients, or fulfilling many other duties traditionally held by physicians. Consequently, a limited patient-physician relationship should be considered to exist during

isolated assessments of an individual's health or disability for an employer, business, or insurer.

The physician has a responsibility to inform the patient about important health information or abnormalities that he or she discovers during the course of the examination. In addition, the physician should ensure to the extent possible that the patient understands the problem or diagnosis. Furthermore, when appropriate, the physician should suggest that the patient seek care from a qualified physician and, if requested, provide reasonable assistance in securing follow-up care. (I)

Issued December 1999 based on the report "Patient-Physician Relationship in the Context of Work-Related and Independent Medical Examinations," adopted June 1999.

Ariz. 2003 Employee appealed summary judgment and dismissal in malpractice action against a radiologist and x-ray company for failure to inform her of medical results that could have led to an earlier diagnosis of lung cancer. Employee was referred by her employer to the radiologist for a chest x-ray. The radiologist did not inform the employee of abnormalities noted in his report. Quoting Opinion 10.03, the appellate court held the physician had a duty to directly inform the employee of the results. The x-ray company was not liable however, since the radiologist was an independent contractor. *Stanley v. McCarver, 204 Ariz. 339, 63 P.3d 1076, 1081.*

N.J. 2001 Deceased patient's wife filed a medical malpractice action against a physician who conducted pre-employment screening. The physician failed to inform the deceased about a condition he discovered during the physical. The New Jersey Supreme Court reversed the lower courts and held that a physician under contract with a third party to perform pre-employment physicals has a nondelegable duty to inform the patient of any potentially serious medical conditions. The court quoted Opinion 10.03, expressing the view that, although this may not be a traditional physician-patient relationship, the physician still has a responsibility to inform the patient. *Reed v. Bojarski, 166 N.J.89, 764 A.2d 433, 444.*

N.Y. 2009 Plaintiff in a personal injury action, sued the physician designated by the defendant in that action to conduct an independent medical examination of plaintiff. Plaintiff claimed he was injured during the examination by the physician. The court relied on Opinion 10.03 in distinguishing the relationship between a physician performing an independent medical examination on a person and an examination undertaken in a traditional physician-patient relationship. The court held that the duty owed to the examinee is to perform the examination in a manner so as not to cause physical harm to the examinee. The court found that plaintiff's claim was governed by the statute of limitations for professional malpractice actions. *Bazakos v. Lewis, 12 N.Y.3d 631, 911 N.E.2d 847, 850, 883 N.Y.S.2d 785.*

N.Y. App. 2008 Plaintiff in personal injury action brought suit against physician hired by alleged tortfeasor to conduct statutory medical examination to recover for injuries sustained during examination. The court quoted Opinion 10.03 in determining that a limited patient-physician relationship exists between the physician and the examinee in such a case. The court held that, despite precedent dictating otherwise, there was no physician-patient relationship in this case and that the statute of limitations for negligence should apply, rather than the statute of limitations for medical malpractice actions. *Bazakos v. Lewis, 56 A.D.3d 15, 864 N.Y.S.2d 505, 512, n. 3, rev'd, 12 N.Y.3d 631, 911 N.E.2d 847, 883 N.Y.S.2d 785.*

10.05 Potential Patients

(1) Physicians must keep their professional obligations to provide care to patients in accord with their prerogative to choose whether to enter into a patient-physician relationship.

(2) The following instances identify the limits on physicians' prerogative:

(a) Physicians should respond to the best of their ability in cases of medical emergency (Opinion 8.11, "Neglect of Patient").

(b) Physicians cannot refuse to care for patients based on race, gender, sexual orientation, gender identity, or any other criteria that would constitute invidious discrimination (Opinion 9.12, "Patient-Physician Relationship: Respect for Law and Human Rights"), nor can they discriminate against patients with infectious diseases (Opinion 2.23, "HIV Testing")

(c) Physicians may not refuse to care for patients when operating under a contractual arrangement that requires them to treat (Opinion 10.015, "The Patient-Physician Relationship"). Exceptions to this requirement may exist when patient care is ultimately compromised by the contractual arrangement.

(3) In situations not covered above, it may be ethically permissible for physicians to decline a potential patient when:

(a) The treatment request is beyond the physician's current competence.

(b) The treatment request is known to be scientifically invalid, has no medical indication, and offers no possible benefit to the patient (Opinion 8.20, "Invalid Medical Treatment").

(c) A specific treatment sought by an individual is incompatible with the physician's personal, religious, or moral beliefs.

(4) Physicians, as professionals and members of society, should work to assure access to adequate health care (Opinion 10.01, "Fundamental Elements of the Patient-Physician Relationship"). Accordingly, physicians have an obligation to share in providing charity care (Opinion 9.065, "Caring for the Poor") but not to the degree that would seriously compromise the care provided to existing patients. When deciding whether to take on a new patient, physicians should consider the individual's need for medical service along with the needs of their current patients. Greater medical necessity of a service engenders a stronger obligation to treat. (I, VI, VIII, IX)

Issued December 2000 based on the report "Potential Patients, Ethical Considerations," adopted June 2000. Updated December 2003. Updated June 2008 based on the report "Modification of Ethics Policy to Ensure Inclusion for Transgender Physicians, Medical Students and Patients;" adopted November 2007.

* Considerations in determining an adequate level of health care are outlined in Opinion 2.095, "The Provision of Adequate Health Care."

Journal 2009 Discusses the right of health care professionals to refuse to provide health care services to lesbian, gay, or bisexual (LGB) individuals, because of moral or religious objections, and its impact on access to health care services, including assisted reproduction and elder health care services, for such patients. Concludes physicians should adhere to professional ethical standards to promote LGB patients' autonomy and equal access to care. Quotes Preamble. Cites Opinion 10.05. Reibman, *The Patient Wanted the Doctor to Treat Her in the Closet, but the Janitor Wouldn't Open the Door: Healthcare Provider Rights of Refusal Versus LGB Rights to Reproductive and Elder Healthcare*, 28 *Temp. J. Sci. Tech. & Envtl. L.* 65, 90-91 (2009).

Journal 2006 Explores the legal and ethical issues surrounding concierge medicine. Concludes that concierge medicine is best restricted to a small class of wealthy individuals. Quotes Principle IX and Opinion 8.055. Cites Principle VI and Opinions 8.055, 8.11, 8.115, 9.065, and 10.05. Carnahan, *Law, Medicine, and Wealth: Does Concierge Medicine Promote Health Care Choice, or is it a Barrier to Access?*, 17 *Stan. L. & Pol'y Rev.* 121, 149-50, 151, 152, 153-54 (2006).

Fax

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To: House Labor and Commerce

Fax: 465-3835 Pages: 6 (counting this one)

Phone: Date: 3-9-11

Re: CC:

• Comments:

HB 122 Testimony of Wayne Aldenhoff

HB-122

Wayne

Testimony of W. Aderhold

350 Grubstake Ave
Homer, AK 99603

March 9, 2011
House - Labor & Commerce

Chairman Olson & Members of the Committee,

I'm speaking **for** HB-122 today representing myself and other like-minded consumer-patients who utilize naturopathic doctors for delivery of their primary or secondary healthcare.

I'm 61 years old, have resided in AK for 36 of those years, and plan to live out my days here. My college degrees are in civil engineering and my work is construction project management. I've also had some direct experience in healthcare as a volunteer EMT with my local fire department in the 70's and 80's and nursing in a refugee camp in Thailand for 3 months. I also served on the Operating Board of my local hospital for a few years (1997-2000) and managed construction on the hospital for the Borough. Both experiences gave me insight into governance structure as well as behavior of the "players" (the Board, the administration and the doctors). Most importantly as applies to HB-122 I began taking a much more active role in my health & healthcare choices about 20 years ago when I realized not only was I not indestructible but that I had options in choosing my healthcare, and that the best route for me in the long term might also require not only going against "the flow" but also digging into my own pockets to pay for some of my choices. Looking back now I'm convinced I've made a good choice by taking the naturopathic route, including my initial step with a serious low back injury (1993) .... And also dealing with cancer (2002) ... as well as everything in between. During this period I started taking more responsibility for decisions which led to more self-education.

So, why should you listen to my views on this bill? In order to best serve consumers you should assure that the two "schools" of primary medical care are on an equal footing and fully empowered to practice in Alaska. From a financial perspective, you and I have a common interest since I value my health as nt chief asset and so I make decisions with the long haul in mind, which includes paying out of pocket when necessary. The only hope for flattening and then reversing today's upward curve in "healthcare" costs is for consumers to take responsibility for their health and care where they are able to, thereby cutting back on expenses that should rightfully be labeled "damage control" (not "healthcare"). Naturopaths, in their primary care role, are trained to teach their patients these skills.

We patient-consumers deserve to have a fully functional naturopathic option, which means:

- governance of the "trade" by a Board composed of peers
- maximizing the effectiveness of the "trade" by allowing to use all the skills they are willing to be responsible for, including access to the pharmacy

And why do I believe Government needs to be involved in this process? I've learned in my brief study of the history of the two schools of medicine that the saying is true: "If men were angels, there would be no need for government". Since the Civil War the school of medicine that formed the roots of today's naturopathic school has gone from a rise to predominance around the turn of the century to near extinction in the 1920's, and now a resurgence. A major component of this drama has been the struggle over prescriptive rights and with few exceptions it is currently the domain of the allopaths. Strange as it may seem today, there was a brief time when the pharmaceutical industry gained enough political clout to make it illegal for doctors to prescribe but wisdom overtook greed and the law was eventually

overturned. Concern for the welfare of the patient has usually taken a back seat to business interests throughout the history of pharmaceuticals. The notable exception to this has been with the doctors who prescribe from the principle that "less is more" and it's not hard to see why this principle is counter to the financial interests of someone who makes more money when a patient takes more drugs for a longer period. I have a strong preference for having my prescriptions limited to the minimum necessary and written by an ND due to their inherent tendency to err on the side of letting my body heal itself whenever possible.

I understand legislative concerns regarding malpractice, but that should truly be a function of the Board once it is established (and points out the immediate need to pass HB-122 into law so that we do have a mechanism to deal with this possibility). From my personal experience with ND's over 18 years, I can say unequivocally that the concept of malpractice has never been even a remote factor in any treatment. I know something about malpractice in general from my experience on the hospital Board when we instituted the requirement for credentialed medical staff to qualify for malpractice insurance. What I learned from my research was that the bulk of malpractice claims were generated by a very small number of doctors and that in nearly every case they arose due to a failure of the medical staff to police its own ranks (ie, there was plenty of warning before significant incidents arose.)

My vision of a healthy coexistence of the two schools of medicine in AK is represented by joint knowledge sharing and transfer in the continuing education efforts required by proper governance, where each can gain from the knowledge of the other. This is already happening where entities like the Institute for Functional Medicine are assuming a "bridge" role in organizing symposia with AMA continuing education accreditation where providers from all disciplines, but particularly MD's and ND's are treated with equality and respect.

Let's move to the future of a vibrant healthcare system for Alaska by passing HB-122 into law now.
I'm open to questions and welcome the possibility of more in depth discussion with any Legislative staff either via teleconference or in person (I traveled to Juneau last year for this bill and would do so again).

Respectfully,

attachments:
-Inst. Functional Med.-"Confronting Cancer as a Chronic Disease",May '10
-copy of book cover: "Divided Legacy" by Coulter, vol III

Note: subject is "primary care" &
7 MD's + 4 ND's are presenters.

Also note: this IFM session qualified for
24 AMA PRA Category 1 Credits of continuing ed.

Confronting Cancer as a Chronic Disease:

Primary Care Takes a 360-degree View

PROGRAM SCHEDULE

THURSDAY, MAY 20 (8:00 am – 5:30 pm)

Introductions *David Jones, MD*

Looking Anew at Cancer *Jeffrey Bland, PhD, FACN, CNS*

New Strategies for Underlying Mechanisms of Cancer *Jeffrey Bland, PhD, FACN, CNS*

Clinical Conundrums: Dealing with Incomplete Information in the Assessment, Prevention and Treatment of Cancer *Dwight McKee, MD*

The Art and Science of an Integrative Approach to Cancer *Mary Hardy, MD*

Panel Discussion *Jeffrey Bland, PhD, FACN, CNS; Dwight McKee, MD; Mary Hardy, MD*

FRIDAY, MAY 21 (8:00 am–6:00 pm)

Synthesis and Introductions *Jeffrey Bland, PhD, FACN, CNS*

Pliable Phenotypes: Changing the Way We View Cancer *Dean Ornish, MD*

Diet and Nutrition in Cancer Prevention: Separating Fact from Fiction *Nancy Emenaker, PhD, MEd, RD*

The Role of Environmental Toxins in Cancer Development *Gina Solomon, MD, MPH*

Questions and Answers

CONCURRENT SESSIONS SCHEDULE

2:30–4:00	**FRIDAY EARLY CONCURRENT SESSIONS**	
1A	Prioritizing the Practical Steps in Reducing Cancer Risks from Environmental Sources	*Gina Solomon, MD, MPH*
1B	Evaluating the Evidence of Controversial Cancer Treatments	*Dwight McKee, MD*
1C	Integrating Dentistry in Cancer Prevention	*Mary Ellen Chalmers, DMD*
1D	Soy, Phytoestrogens and Cancer: Prescription or Avoidance	*Mark Messina PhD, MS*
4:00–4:30	**AFTERNOON BREAK** *(Refreshments in exhibit hall)*	
4:30–6:00	**FRIDAY LATE CONCURRENT SESSIONS**	
1E	Prostate Cancer and PSA: Evaluating the Evidence	*Peter Carroll, MD, MPH, FACS*
1F	Glucosinalates in Cancer Prevention	*Jed Fahey, MS, Sc.D*
1G	SNPs, Genetic Risks and Cancer Prevention	*Ruth DeBusk, PhD, RD*
1H	Conversations with Cancer Patients	*Moshe Frenkel, MD and Mary Hardy, MD*

PROGRAM SCHEDULE

SATURDAY, MAY 22 (8:00 am–6:00 pm)

Synthesis and Introductions *Jeffrey Bland, PhD, FACN, CNS*

Weighing the Risks and Benefits of Adjunctive Therapies during Chemotherapy and Radiation *Lise Auschuler, ND, FABNO*

The Role of Antioxidants and Immunostimulants in Cancer Prevention and Treatment *Tim Birdsall, ND, FABNO*

Why Attitudes and Beliefs Matter in Cancer Care *Anne Coscarelli, PhD*

Concurrent Sessions *2:30 pm – 6:00 pm*

SUNDAY, MAY 23 (8:00 am–1:00 pm)

Synthesis and Introductions *Jeffrey Bland, PhD, FACN, CNS*

Long-term Biologic Strategies for Secondary Prevention of Cancer *Keith Black, MD*

Looking to the Future of Integrative Cancer Care *Dan Rubin, ND, FABNO*

Living Longer and Better: Cancer Survivorship Challenges and Opportunities *Mitchell Gaynor, MD*

Concluding Remarks *David Jones, MD*

CONCURRENT SES

2:30–4:00	SATURDAY EARLY C
2A	Nutritional and Botan Cancer Side Effects
2B	Guiding Patients in Cc
2C	The Use and Misuse o
2D	Intravenous Nutrition
4:00–4:30	AFTERNOON BREAI
4:30–6:00	SATURDAY LATE CC
2E	Botanical Medicine in
2F	Individualizing Food a
2G	10 Essential Take-hon
2H	Biomarkers for Prima Reoccurrence of Cern

Continuing Education C

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For MDs ar 24 *AMA PR* with the ex

Attendees credits at I

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The La Costa Resort and Spa your reservations, be sure to the Institute for Functional M reservations early! A block of April 26, 2010 at the reduced call the Hotel at 800-854-500

The Institute for Functional Medici

Page 3 of 5

CONCURRENT SESSIONS SCHEDULE

2:30–4:00	FRIDAY EARLY CONCURRENT SESSIONS	
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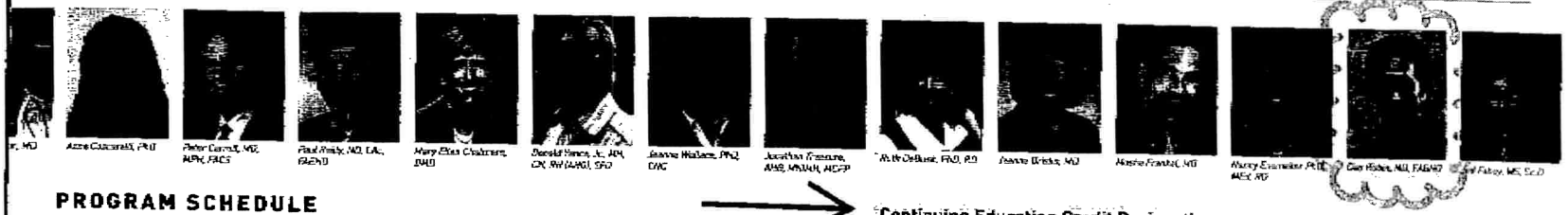
Adjuvant cancer therapy Types of cancer treatment that are used as adjuvant therapy include:

Chemotherapy
Hormone therapy
Radiation therapy
Immunotherapy
Targeted therapy
[edit] See also

CONCURRENT SESSIONS SCHEDULE

2:30–4:00	SATURDAY EARLY CONCURRENT SESSIONS	
2A	Nutritional and Botanical Adjunctive Treatments for Common Cancers	*Paul Reilly, ND, LAc, FABNO*
	Guidi	*Anne Coscarelli, PhD*
	The L	*Jonathan Treasure, AHG, MNIMH, MCFP*
	Intrav	*Jeanne Drisko, MD*
	:30 AFTE	
	:00 SATURDAY LATE CONCURRENT SESSIONS	
2E	Botanical Medicine in Cancer: Case Series Results	*Donald Yance, Jr., MH, CN, RH (AHG), SFO*
2F	Individualizing Food and Nutrition Therapy in Cancer Care	*Jeanne Wallace, PhD, CNC*
2G	10 Essential Take-home Lessons about CAM and Cancer	*Moshe Frenkel, MD*
2H	Biomarkers for Primary Prevention and Secondary Reoccurrence of Common Cancers	*Mitchell Gaynor, MD*

primary provider for W. Aderhold in 2002 (adjuvant therapy) for malignant melanoma in Arizona and follow up for prevention of re-occurrance; referred by J. Harmon ND (Anchorage), follow up care coordinated locally with P. Huffman ND (Homer)



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Concluding Remarks *David Jones, MD*

Continuing Education Credit Designations

IFM is accredited by the Accreditation Council for Continuing Education to provide continuing medical education to physicians.

For MDs and DOs: IFM designates this educational activity for a maximum of *24 AMA PRA Category 1 Credits.™* Physicians should only claim credit commensurate with the extent of their participation in this activity.

Attendees with other degrees will find details about continuing medical education credits at functionalmedicine.org.

Hotel Information

The La Costa Resort and Spa, Carlsbad, CA—When making your reservations, be sure to mention that you are attending the Institute for Functional Medicine Symposium. Make your reservations early! A block of rooms is being held for us until April 26, 2010 at the reduced rate of $205. For reservations, call the hotel at: 800-854-5000 or 760-438-9111.

The Institute for Functional Medicine (IFM), Evolving Functional Medicine in Clinical Practice, and AFMCP

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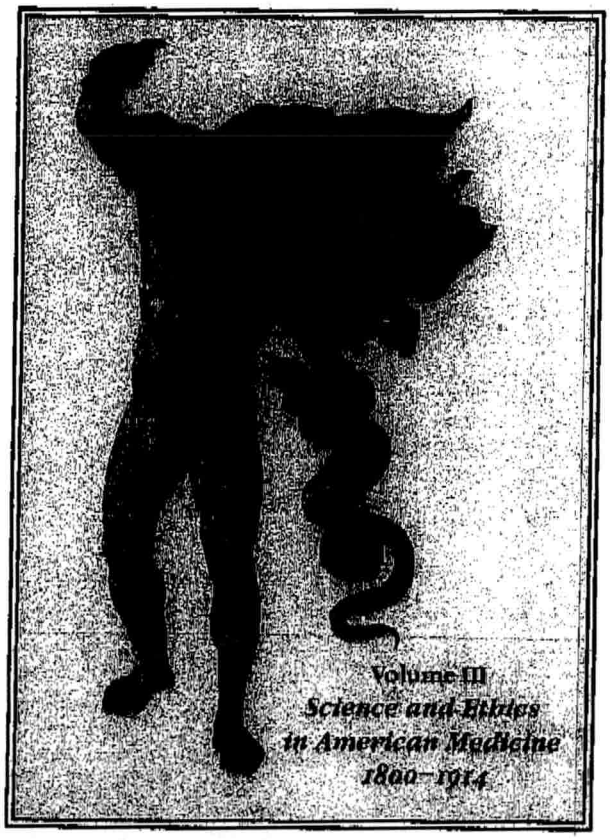
THE CONFLICT BETWEEN HOMOEOPATHY AND THE AMERICAN MEDICAL ASSOCIATION

LEGACY



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