AMA AMERICAN MEDICAL ASSOCIATION

Jesse M. Ehrenfeld, MD, MPH
PRESIDENT

jesse.ehrenfeld@ama-assn.org

August 22, 2023

Brandi Webb
Program Coordinator
3E Program for Social Justice and Change
3ecourses@gmail.com

Ms. Webb,

Thank you for sharing your and your students' concerns about Principle VI of the American Medical Association's (AMA) *Principles of Medical Ethics.* Although I believe the AMA House of Delegates did not intend to do so when it adopted Principle VI in 2001, you are correct to point out that on its face, the principle is open to a broader, problematic interpretation.

Let me respond to your concerns about the AMA *Code of Medical Ethics* by offering some context. The *Code* includes both the *Principles* and *Opinions* of our Council on Ethical and Judicial Affairs (CEJA) that interpret those principles across a wide variety of issues in medicine and health care. Multiple *Opinions* in the *Code* help to limit the latitude Principle VI gives physicians with respect to their relationships with patients. It is important to note that the *Code* and its associated *Opinions* must be read as one unified document. Therefore, one should consider all relevant provisions from throughout the *Code* when making decisions regarding the ethical practice of medicine. Allow me to share relevant passages from some *Opinions* by way of example.

Importantly, *Opinion 1.1.2*, "Prospective Patients," holds that:

> As professionals dedicated to protecting the well-being of patients, physicians have an ethical obligation to provide care in cases of medical emergency. Physicians must also uphold ethical responsibilities not to discriminate against a prospective patient on the basis of race, gender, sexual orientation or gender identity, or other personal or social characteristics that are not clinically relevant to the individual's care.

Opinion 1.1.7, "Physician Exercise of Conscience," similarly limits physicians' latitude in choosing whom to serve or what services to provide. This guidance recognizes that, within certain constraints, physicians should be able to act in accordance with their deeply held, identity-conferring beliefs. As this guidance notes,

> Physicians' freedom to act according to conscience is not unlimited, however. Physicians are expected to provide care in emergencies, honor patients' informed decisions to refuse life-sustaining treatment, and respect basic civil liberties and not discriminate against individuals in deciding whether to enter into a professional relationship with a new patient.

Opinion 8.5, “Disparities in Health Care,” similarly provides that:

> Stereotypes, prejudice, or bias based on gender expectations and other arbitrary evaluations of any individual can manifest in a variety of subtle ways. Differences in treatment that are not directly related to differences in individual patients’ clinical needs or preferences constitute inappropriate variations in health care. Such variations may contribute to health outcomes that are considerably worse in members of some populations than those of members of majority populations. This represents a significant challenge for physicians, who ethically are called on to provide the same quality of care to all patients without regard to medically irrelevant personal characteristics.

Opinion 11.1.3, “Allocating Limited Health Care Resources,” addresses concerns about discrimination when it instructs physicians and policymakers as follows:

> Individually and collectively through the profession, physicians should advocate for policies and procedures that allocate scarce health care resources fairly among patients, in keeping with the following criteria:
>
> > (a) Base allocation policies on criteria relating to medical need, including urgency of need, likelihood and anticipated duration of benefit, and change in quality of life. In limited circumstances, it may be appropriate to take into consideration the amount of resources required for successful treatment. It is not appropriate to base allocation policies on social worth, perceived obstacles to treatment, patient contribution to illness, past use of resources, or other non-medical characteristics.
> >
> > (b) Give first priority to those patients for whom treatment will avoid premature death or extremely poor outcomes, then to patients who will experience the greatest change in quality of life, when there are very substantial differences among patients who need access to the scarce resource(s).
> >
> > (c) Use an objective, flexible, transparent mechanism to determine which patients will receive the resource(s) when there are not substantial differences among patients who need access to the scarce resource(s).

As an organization, the AMA recognizes that such guidance does not directly address underlying social drivers of health disparity and discrimination in the United States, many of which lie outside the domain of medicine as a profession. However, in a report adopted in June this year, “Responsibilities to Promote Equitable Care,” CEJA expanded the scope of its work to provide guidance not just to individual physicians in their interactions with patients (and fellow health care professionals), but to health care institutions broadly in relation to their own operations and the communities they serve as well in setting out responsibilities to promote equitable care. The “preamble” to this new guidance notes (which will officially be an opinion in the *Code* after the November meeting of the AMA):

> Enduring health disparities across patient populations challenge [medicine’s] duties of fidelity. Disparities reflect the habits and practices of individual clinicians and the policies and decisions of individual health care institutions, as well as deeply embedded, historically rooted socioeconomic and political dynamics. Neither individual physicians nor health care institutions can entirely resolve the problems of discrimination and inequity that underlie health disparities, but they can and must accept responsibility to be agents for change.

The full report identifies additional justice-relevant policies throughout the *Code* and a copy of the report is attached for your information.

You and your students also raise important points about AMA's history of discrimination against African American physicians and patients. You are correct that in many respects our AMA as an organization has fallen short of the ideals of the medical profession. Let me note three important activities that our AMA has undertaken: 1) AMA's formal apology to African American physicians; 2) our convening of the Commission to End Health Care Disparities; and 3) most recently, establishing the Center for Health Equity at the AMA.

Briefly, in 2008, following an intensive three-year review of our AMA history carried out by staff in our Ethics group, AMA publicly acknowledged and apologized to the National Medical Association and the African American community for its historical failings. In 2004, we convened the Commission to End Health Care Disparities, bringing together leaders from multiple professional organizations to better understand disparities in American health care and to explore opportunities for change to reduce disparities. The Commission is now an independent entity.

In 2018, at the direction of the AMA House of Delegates, we established the Center for Health Equity, whose work focuses both on promoting equity within the AMA as an organization and on strategies to improve access to and quality of care for historically marginalized and minority populations across the country. More recently, a task force was established to "guide organizational transformation within and beyond the AMA toward restorative justice to promote truth, reconciliation, and healing in medicine and medical education."

Finally, AMA's *Principle of Medical Ethics* IX states that "a physician shall support access to medical care for all people." It is essential that no AMA principle (including Principle VI) be considered in isolation. For this reason and others noted above, I do not see that the AMA or its *Code of Medical Ethics* allows or tolerates discrimination. However, it may be time to clarify Principle VI. As a practical matter, amending Principle VI will require action by the House of Delegates and I have shared your concerns with leadership of the House.

On behalf of the American Medical Association, I thank you and your students for your candor and willingness to voice your concerns. Should you have additional questions, please contact Amber Comer, PhD, Director of Ethics Policy, at amber.comer@ama-assn.org.

Sincerely,

Jesse M. Ehrenfeld, MD, MPH

Enclosure

cc: Lisa Bohman Egbert, MD
James L. Madara, MD
Aletha Maybank, MD, MPH