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Letter of Introduction

With its founding in 1847, the American Medical Association (AMA) dedicated itself to promoting the art and science of medicine. This updated edition of the Code of Medical Ethics (Code) embodies this commitment in the 21st century, as the Code has for generations of physicians over the past 169 years. Today, as when it was first adopted, the Code serves two key ends in medicine: it articulates the values that ground the profession and sets out the expectations to which physicians should be held in their roles as healers, educators, scientists, and leaders in health care organizations and institutions.

In setting out the highest ideals of medical professionalism, the Code provides a framework for relationships of trust between patients and their physicians, regardless of specialty or geographic location, and between the profession as a whole and society.

Moreover, the Code provides practical guidance for physicians as they confront the challenges of day-to-day practice. Far more than a set of rules to be followed, the Code, through the Opinions of the AMA Council on Ethical and Judicial Affairs (Council), helps physicians think through what is at stake as they engage patients and work with colleagues to reach ethically sound decisions in complex situations.

As stewards of the Code, the AMA Council undertook the significant project of updating and consolidating this key professional resource to ensure that the Code of Medical Ethics continues to fulfill its role well into the future as the ethical touchstone for the profession of medicine.

Over the course of eight years, through a rigorous process of review and consultation, the council painstakingly updated previously issued Opinions for timeliness, clarity, and consistency. The final product now features a revised chapter structure, an updated index, and a fresh new look that make guidance easier to find, easier to read, and easier to apply in day-to-day practice.

To address the challenges of 21st-century medicine, the AMA has recently launched major initiatives that span such important areas as improving outcomes for patients, transforming medical education, and nurturing sustainable, high-quality practices. Today, as part of its enduring mission, the AMA is proud to present this next generation’s edition of medicine’s national professional Code of Medical Ethics.

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The most cited 20th-century paper on medical education is Francis Peabody’s 1927 “The Care of the Patient” (Peabody FW. The care of the patient. JAMA. 1927;88(12):877–882.). In that paper, Peabody raised two central criticisms of young doctors: that they received inadequate training on how to take care of patients and that their education was primarily in the “impersonal” hospital, so they, therefore, lacked humanity and compassion in caring for patients.

It is worth recalling that in 1847, 80 years before Peabody’s article, the American Medical Association (AMA) was founded in response to a national problem of poor standards in medical and professional education. In the 1840s, the quality of medical schools was highly variable, and some schools required only 16 weeks of medical college instruction to qualify as a practicing physician. As a result, many poorly trained physicians were providing low-quality, inadequate, and “unprofessional” care to patients.

With leadership from Dr. Nathan Smith Davis, often regarded as the “father of the AMA,” a national convention of medical societies meeting in New York City in May 1846 resolved to create a national organization for the medical profession. The goals of the new organization would be to develop a “uniform and elevated standard of requirements for the degree of M.D.” and to adopt a single code of medical ethics to govern all physicians in the U.S. The 1846 convention appointed committees to report back on these priorities at what would be the national organization’s inaugural meeting in Philadelphia the following year.

Thus, in May 1847, the newly organized AMA unanimously adopted a remarkable 5000-word document by Drs. Isaac Hayes and John Bell that was essentially the first national code of medical ethics ever written, one that applied high, collective professional standards to individual practitioners across the country. The code was written for doctors by doctors and aimed to improve clinical practice and patient care by incorporating ethical and professional standards into the daily activities of physicians.

Some of the extraordinary elements of the 1847 ethics code of the AMA included:

- The medical profession was called on to treat patients with “attention, steadiness and humanity.” (Chapter 1, Article 1, No. 2)
- Physicians were called upon to offer “. . . counsels, or even remonstrances . . . with politeness and a genuine love of virtue, accompanied by a sincere interest in the welfare of the person to whom they are addressed.” (Chapter 1, Article 1, No. 7)
- The profession could not “. . . abandon a patient because the case is deemed incurable.” (Chapter 1, Article 1, No. 5)
- The profession acknowledged “. . . poverty . . . as presenting valid claims for gratuitous service.” (Chapter 3, Article 1, No. 3)
- The profession accepted that “when pestilence prevails” physicians had a “. . . duty to face the danger, and to continue their labors for the alleviation of suffering, even at the jeopardy of their own lives.” (Chapter 3, Article 1, No. 3)
The code established guidelines for both doctors and patients in their interactions and also for the reciprocal relationship between doctors and society.

The AMA *Code of Medical Ethics* “set a new moral standard in medicine not only for America but also for the world. . . . The grand moral vision inscribed in the 1847 Code of Ethics established the newly founded American Medical Association as the preeminent moral and political voice of American medicine. Throughout the rest of the nineteenth Century, the AMA’s Code of Ethics was the most commonly printed medical document in the English language.”

In fact, during the second half of the 19th century, the AMA’s 1847 *Code of Medical Ethics* was viewed as the greatest achievement of the AMA. Jumping ahead to the mid-1970s, almost 130 years after the AMA *Code of Medical Ethics* was written, several colleagues and I developed a new field in medicine that we called clinical medical ethics. Our goal was to create a new, applied medical discipline that would improve medical care by focusing on the practice of medicine itself and by keeping at its core the patient-physician relationship. Whereas bioethics looked to philosophy, theology, and law for its ethical justifications, the foundation of clinical medical ethics is grounded squarely in medicine as a profession.

Clinical medical ethics aims to make ethics patient-centered in a new way. We wanted to improve patient outcomes by strengthening the patient-physician relationship and by encouraging physicians to reach decisions that incorporate the ethical issues that arise routinely in everyday clinical practice. In the United States, for the past 40 years, the clinical medical ethics movement has integrated ethical issues into practice, teaching, and research. This movement has defended and retained the central importance of the patient-physician relationship, a relationship that emphasizes patient autonomy, patient-centered care, and respect for the patient.

Clinical medical ethics has become so well integrated into current practice that physicians often don’t realize that they are “doing” clinical ethics when they tell patients the truth, or when they obtain informed consent for a procedure, or when they make decisions based upon shared decision making, or when they work with surrogate decision makers in cases when the patient lacks capacity. These and other clinical ethical issues have become part of everyday medical practice, and many of them have become widely accepted as the standard of care.

While my colleagues and I take pride in having contributed to the development of clinical medical ethics, it is now clear to me that our work in developing clinical medical ethics was not a new invention. Rather, in the 1970s my colleagues and I were rediscovering or “reinventing” the clinical medical ethics model that had originally been created by the AMA in 1847. The AMA *Code of Medical Ethics* was the first national medical ethics code in the world. The AMA’s *Code of Medical Ethics* of 1847 was not a philosophical treatise on medicine but rather a statement about medical professionalism and ethics that focused on patients, physicians, their professional relationships, the quality of patient care, and professional standards and duties. Each of these issues, which were originally addressed in the 1847 ethics code, remains a central component of the modern clinical medical ethics movement.

In my view, Chapter 1, Article 1, of the AMA’s *Code of Medical Ethics* anticipates clinical medical ethics:

Duties of Physicians to their Patients. A physician should not only be ever ready to obey the calls of the sick, but his mind ought also to be imbued with the greatness of his mission, and of the responsibility he incurs in its discharge. . . . Physicians should therefore minister to the sick with due impressions of the importance of their office; reflecting that the ease, the health, and the lives of those committed to their charge depend on their skill, attention, and fidelity. . . . Every case committed to the charge of a Physician should be treated with attention, steadiness and humanity. . . . (Chapter 1, Article 1, Nos. 1 and 2)2
Each of these ideas and beliefs has been echoed and restated as part of the modern movement to develop and advance clinical medical ethics.

In an effort to meet the demands of a changing medical, scientific, and social world, the AMA's *Code of Medical Ethics* is a living document that has evolved in the 170 years since it was first written. Through its many revisions since then, major and minor, the *Code of Medical Ethics* has articulated the values and ethical standards to which members of the medical profession commit themselves. As a national standard, the *Code of Medical Ethics* addresses all physicians and physicians-in-training, regardless of location or specialty, and provides ethical guidance even when state medical societies or specialty organizations do not. It plays a vital role in enabling and strengthening medicine’s ability to control its own educational, clinical, and ethical standards, a key feature of self-regulation that is essential for any professional organization.

The newly revised, modernized 2016–2017 version of the *Code of Medical Ethics* is the most extensive revision of the *Code* since 1957. In 1957, the 47 Articles of the *Code of Medical Ethics* were recast as succinct principles accompanied by annotations by the AMA’s Judicial Council, the forerunners to what are now the Opinions of the Council on Ethical and Judicial Affairs (Council).

The current revisions aim to meet the needs of practicing physicians and teachers by providing guidance that is easy to find, timely, clear, and consistent. In this modernized *Code of Medical Ethics*, the Council has organized guidance around specific topics in separate chapters in a clear and orderly way. For example, the titles of five early chapters in the newly revised edition of the Opinions are:

- Patient-Physician Relationships
- Consent, Communication and Decision Making
- Privacy, Confidentiality, and Medical Records
- Genetics and Reproductive Medicine
- Caring for Patients at the End of Life

Contrast these chapters with previous editions of the *Code of Medical Ethics*, in which material covering a given topic was often dispersed and inconvenient to locate and use. For example, in the 2014-2015 edition of the *Code of Medical Ethics*, five early chapters were:

- Opinions on Social Policy Issues
- Opinions on Interprofessional Relations
- Opinions on Hospital Relations
- Opinions on Confidentiality, Advertising, and Communications Media Relations
- Opinions on Fees and Charges

The chapter on social policy issues in the 2014-2015 edition included Opinions on a wide range of disparate topics, including mandatory parental consent to abortion; physician participation in interrogation; subject selection for clinical trials; genetic engineering; transplantation of organs from living donors; withholding or withdrawing life-sustaining treatment; the use of radio-frequency ID devices in humans; and others.

Similarly, in the 2014-2015 edition, information and opinions about the patient-physician relationship were dispersed in six separate chapters. By contrast, in the newly revised edition, all information about the patient-physician relationship is consolidated into a single chapter, Chapter 1.

I have used the AMA *Code of Medical Ethics*, particularly the Opinions of the Council, for more than 45 years. I frequently refer to the Opinions when I am struggling with an ethical decision in my clinical practice or when I am invited as a clinical ethics consultant to help patients or families reach a clinical-ethical decision. I also have used the Opinions frequently to teach medical students, residents, and fellow practitioners. Finally, in my writing and research on clinical ethics, I find the Council Opinions an excellent place to start my work because the views in the Opinions are not only clear and succinct but also supported by previous ethical analyses and legal opinions. The Opinions state clearly whether potential actions are ethical, unethical, or open to discussion and deliberation.
I must confess that in my 45 years of practice I have never read the Opinions from front to back as one might read a novel. Rather, I use the Opinions for particular problems that I encounter in my practice or as a reference source. Frequently, I find myself starting with a particular question or issue and then expanding my search to related topics.

Readers will find this updated edition of the Opinions more user-friendly than ever before. First, as noted, the Opinions consolidate similar issues within a single chapter rather than scattering them throughout the volume. Second, there is a new and consistent format that is used uniformly for all Opinions. Each Opinion starts with a short statement of the key ethical values, considerations, and challenges that are raised by the specific issue. The Opinion then offers a concise description of the clinical context in which the ethical issue arises. Finally, the Opinion offers guidance for physicians, guidance that aims to be practical and concrete without being rigidly prescriptive. This newly revised edition, which required eight years to complete, makes this edition of the Code of Medical Ethics a far more accessible and useful resource than it has previously been for physicians, teachers, and students.

The 1847 AMA Code of Medical Ethics was a revolutionary document that aimed to establish a national standard for physicians’ professional behavior. The 2016 update of the Opinions of the Code of Medical Ethics reinforces the primary focus on professional ethical standards and does so in a way that is accessible to busy practicing physicians who hope to apply clinical ethics standards to improve the care and outcome of patients.

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References
The Code of Medical Ethics (Code) of the American Medical Association (AMA) is rooted in an understanding of the goals of medicine as a profession, which dates back to the 5th century BCE and the Greek physician Hippocrates, to relieve suffering and promote well-being in a relationship of fidelity with the patient. As adopted by the young AMA in 1847, the Code drew significantly on the work of the English physician-philosopher Thomas Percival, whose 1803 code of medical ethics set standards of conduct relative to hospitals and other charities.

The Code is a living document that has evolved as medicine and society have changed over time. The first edition in 1847 articulated in some detail the standards of ethical conduct for physicians in relation to their patients, fellow physicians, and the profession at large, and the public in three chapters, each of which also outlines the reciprocal obligations of the other parties. With minor copyediting along the way, the Code remained largely unchanged until 1903, when its language was updated and provisions addressing the obligations of patients and society were eliminated. At that time, the document was retitled as Principles of Medical Ethics (Principles). In 1949, the Principles were further revised: content was reorganized and language and guidance updated to reflect the significant changes that had taken place in medical practice over the preceding decades. Debate continued, however, and six years later the chapter structure of the original document was abandoned and the Principles were recast in the form of a preamble and 47 separate articles.

In 1957 further revisions to the restructured Principles removed “superfluous wording and matters of medical etiquette” and distilled the Principles to a preamble and 10 statements of core values and commitments, “leaving to the [then] Judicial Council the question of interpretation of these ethical Principles.” (Minor changes to the Principles were adopted in 1980 and 2001.)

The 1957 Principles appeared in the Journal of the American Medical Association (JAMA) in June 1958, accompanied by interpretive annotations. Those annotations subsequently evolved into the opinions of the Council on Ethical and Judicial Affairs (CEJA), the 1985 successor to the Judicial Council. Early annotations were offered without explanation, but since the late 1970s, CEJA reports have presented background analyses supporting the guidance set out in individual opinions. Today’s Code of Medical Ethics...
consists of the Principles and CEJA’s interpretive opinions. New opinions are issued at the annual or interim meetings of the AMA House of Delegates as new CEJA reports are adopted.

By the time CEJA launched its project to comprehensively review the Code in 2008, opinions totaled some 220 separate statements that differed markedly in form and specificity, topics ranging from abortion to xenotransplantation. The Code had become unwieldy—guidance on individual topics was hard to find; opinions varied significantly as to whether they offered general guidance or highly prescriptive statements. Some guidance was directed narrowly to dilemmas at the bedside; other guidance broadly to issues of social policy.

CEJA updated guidance that referred to outdated science or clinical practice, was overly prescriptive as a statement of ethical responsibility, or focused unduly on operational or specifically legal considerations rather than ethical responsibilities as such. In some instances, the CEJA consolidated multiple opinions on the same or closely related topics into a single, more comprehensive opinion, where there was significant overlap in guidance. In other instances, CEJA extracted and recombined salient guidance scattered across two or more opinions into new, more clearly focused statements.

Throughout, CEJA’s intent was to respect the accumulated wisdom represented in its constituent opinions; to ensure that guidance remains timely and useful; and to strike a balance between offering general rules for acting and providing tools for thinking about the ethical challenges physicians encounter as practicing clinicians and leaders in a rapidly changing health care environment.
The nine Principles of Medical Ethics are the primary component of the Code. They describe the core ethical principles of the medical profession. A single Principle should not be read in isolation from others; the overall intent of the nine Principles, read together, guides physicians’ behavior.

The AMA House of Delegates has the authority to establish the Principles of Medical Ethics. However, the Council on Ethical and Judicial Affairs is responsible for determining the AMA’s positions on ethical issues through its interpretations of the Principles, which are expressed in the Opinions. Each Opinion identifies the Principle(s) from which the Opinion is derived.

Preamble

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

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

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

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

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

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

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

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

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

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

Adopted June 1957; revised June 1980; revised June 2001.
Just as the AMA *Principles of Medical Ethics* are not laws, but standards of conduct, so too the Opinions in the *Code of Medical Ethics (Code)* are not laws or rules. They are guidance that identifies the essentials of ethical behavior for physicians.

Throughout the Opinions of the *Code*, the Council on Ethical and Judicial Affairs uses the words *must*, *should*, and *may* in their common understandings to distinguish different levels of ethical obligation. Use of the word *must* indicates that an action is ethically required of physicians. From the perspective of ethics and professionalism, such actions are near-absolute obligations, not matters about which physicians may use judgment or discretion. The Council uses the word *should* to indicate an action or obligation that is strongly recommended as a matter of professional ethics, but which may have some exceptions. *Should* is used to indicate what is expected of a physician in most instances, absent special circumstances or considerations. *Should* indicates that ethically there is some latitude for physician judgment and discretion. The Council uses *may* to indicate that an action is ethically permissible when qualifying conditions set out in the Opinion are met.

The Council recognizes that circumstances at times impinge on physicians’ ability or opportunity to follow the guidance of the *Code* strictly as written. Recognizing when such circumstances exist and determining how best to adhere to the goals and spirit, if not the absolute letter, of guidance requires physicians to use skills of ethical discernment and reflection. Physicians are expected to have compelling reasons to deviate from guidance when, in their best judgment, they determine it is ethically appropriate or even necessary to do so.

The more stringent the ethical obligation, the stronger the justification required to deviate from it in any specific instance. Obligations indicated by *must* can be reversed or violated only in very rare circumstances, for example, when two or more core ethical values conflict in such a way that it is not possible for the physician to uphold both or all and the physician is forced to decide which value will prevail. Guidance introduced by *should* sets a general expectation for conduct, but permits more latitude for discerning alternative ways to meet the expectation. Obligations indicated by *may* call on the physician to confirm that qualifying conditions are met sufficiently to warrant taking the action addressed in guidance.

The Council also recognizes that guidance is not always equally applicable to every individual physician, depending on the nature of the physician’s practice. Nonetheless, physicians are expected to be aware of guidance that may not be routinely relevant to their practice, to be sensitive to occasions when such guidance might be pertinent, and to respond in keeping with guidance when such situations occur. In this respect too, then, the *Code* relies on the reasonable exercise of judgment.

The AMA *Code* provides ethical guidance for all physicians, regardless of specialty. The AMA recognizes that other physician organizations may also have codes of ethical behavior and that physicians may, at times, have to balance guidance of other professional codes.
Opinions of the AMA Council on Ethical and Judicial Affairs lay out the ethical responsibilities of physicians as members of the profession of medicine. In these opinions, the term “ethical” refers to matters involving moral principles, values, and practices, as well as matters of social policy involving issues of morality in the practice of medicine.

Council opinions articulate the expectations for professional conduct in the areas addressed, at times laying out specific duties and obligations. Conduct that violates these expectations or specific duties and obligations is not acceptable ethically, and is unprofessional. Violations of ethical responsibilities may justify disciplinary actions against a physician’s medical society membership.

The relationship between ethics and law is complex. Ethical values and legal principles are usually closely related, but ethical responsibilities usually exceed legal duties. Conduct that is legally permissible may be ethically unacceptable. Conversely, the fact that a physician who has been charged with allegedly illegal conduct has been acquitted or exonerated in criminal or civil proceedings does not necessarily mean that the physician acted ethically.

In some cases, the law mandates conduct that is ethically unacceptable. When physicians believe a law violates ethical values or is unjust, they should work to change the law. In exceptional circumstances of unjust laws, ethical responsibilities should supersede legal duties.
Caring for patients at the end of life is a privilege that draws deeply on physicians’ profession-defining commitment to alleviate suffering. Medicine’s advancing power to intervene to delay death has proven double-edged, however, tempting physicians, patients, and families to pursue aggressive care that may not always be in the patient’s interest. Interventions intended to prolong life can all too easily come to have the unsought effect of only prolonging death.

Physicians and other health care professionals are challenged to help patients and families identify what matters most to them when cure is not possible and to negotiate difficult decisions about what trade-off to accept between quality of life and length of life, what interventions to accept, and when to refuse efforts to sustain life. Through the process of advance care planning, physicians can help patients and families express their values and preferences, define goals for the patient’s care, and, ideally, identify who will make decisions on the patient’s behalf when he or she can no longer do so.

Encouraging patients to set out their values, goals for care, and treatment preferences in oral or written advance directives helps to ensure that their wishes will guide the recommendations and actions of the health care team and thus to promote respect for patient autonomy and self-determination.

Respect for patients’ right to refuse life-sustaining interventions is central to ethical practice in end-of-life care, and physicians thus have an obligation not to allow their personal beliefs and values to override the decision of a patient who has decision-making capacity. Physicians have a similar responsibility to respect the decisions made by patients’ authorized surrogates. This does not mean, however, that physicians are ethically required to offer or to provide on request interventions that, in their best professional judgment, cannot reasonably be expected to yield the intended clinical benefit or achieve agreed-on goals for care. Rather they have a responsibility to preserve the integrity of medical judgment, to address patients’ or surrogates’ fears and clarify misunderstandings, and to resolve disagreements about care, at the bedside when possible or through consultation with an ethics committee or similar resource when necessary. In all cases, physicians are expected to uphold their obligation to provide compassionate care and not to abandon a patient.

Although their commitment of fidelity to patients is foremost, physicians have further responsibilities to uphold the fundamental values of medicine and therefore not to take actions that are contrary to the role of healer with which they are entrusted.
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5.5 Medically Ineffective Interventions

At times patients (or their surrogates) request interventions that the physician judges not to be medically appropriate. Such requests are particularly challenging when the patient is terminally ill or suffers from an acute condition with an uncertain prognosis and therapeutic options range from aggressive, potentially burdensome life-extending intervention to comfort measures only. Requests for interventions that are not medically appropriate challenge the physician to balance obligations to respect patient autonomy and not to abandon the patient with obligations to be compassionate, yet candid, and to preserve the integrity of medical judgment.

Physicians should only recommend and provide interventions that are medically appropriate—ie, scientifically grounded—and that reflect the physician’s considered medical judgment about the risks and likely benefits of available options in light of the patient’s goals for care. Physicians are not required to offer or to provide interventions that, in their best medical judgment, cannot reasonably be expected to yield the intended clinical benefit or achieve agreed-on goals for care. Respecting patient autonomy does not mean that patients should receive specific interventions simply because they (or their surrogates) request them.

Many health care institutions have promoted policies regarding so-called “futile” care. However, physicians must remember that it is not possible to offer a single, universal definition of futility. The meaning of the term “futile” depends on the values and goals of a particular patient in specific clinical circumstances.

As clinicians, when a patient (or surrogate on behalf of a patient who lacks decision-making capacity) requests care that the physician or other members of the health care team judge not to be medically appropriate, physicians should:

(a) Discuss with the patient the individual’s goals for care, including desired quality of life, and seek to clarify misunderstandings. Include the patient’s surrogate in the conversation if possible, even when the patient retains decision-making capacity.

(b) Reassure the patient (and/or surrogate) that medically appropriate interventions, including appropriate symptom management, will be provided unless the patient declines particular interventions (or the surrogate does so on behalf of a patient who lacks capacity).

(c) Negotiate a mutually agreed-on plan of care consistent with the patient’s goals and with sound clinical judgment.
(d) Seek assistance from an ethics committee or other appropriate institutional resource if the patient (or surrogate) continues to request care that the physician judges not to be medically appropriate, respecting the patient’s right to appeal when review does not support the request.

(e) Seek to transfer care to another physician or another institution willing to provide the desired care in the rare event that disagreement cannot be resolved through available mechanisms, in keeping with ethical guidelines. If transfer is not possible, the physician is under no ethical obligation to offer the intervention.

As leaders within their institutions, physicians should encourage the development of institutional policy that:

(f) Acknowledges the need to make context-sensitive judgments about care for individual patients.

(g) Supports physicians in exercising their best professional judgment.

(h) Takes into account community and institutional standards for care.

(i) Uses scientifically sound measures of function or outcome.

(j) Ensures consistency and due process in the event of disagreement over whether an intervention should be provided.

5.6 Sedation to Unconsciousness in End-of-Life Care

The duty to relieve pain and suffering is central to the physician’s role as healer and is an obligation physicians have to their patients. When a terminally ill patient experiences severe pain or other distressing clinical symptoms that do not respond to aggressive, symptom-specific palliation, it can be appropriate to offer sedation to unconsciousness as an intervention of last resort.

Sedation to unconsciousness must never be used to intentionally cause a patient’s death.

When considering whether to offer palliative sedation to unconsciousness, physicians should:

(a) Restrict palliative sedation to unconsciousness to patients in the final stages of terminal illness.

(b) Consult with a multi-disciplinary team (if available), including an expert in the field of palliative care, to ensure that symptom-specific treatments have been sufficiently employed.
and that palliative sedation to unconsciousness is now the most appropriate course of treatment.

(c) Document the rationale for all symptom management interventions in the medical record.

(d) Obtain the informed consent of the patient (or authorized surrogate when the patient lacks decision-making capacity).

(e) Discuss with the patient (or surrogate) the plan of care relative to:

   (i) degree and length of sedation;

   (ii) specific expectations for continuing, withdrawing, or withholding future life-sustaining treatments.

(f) Monitor care once palliative sedation to unconsciousness is initiated.

Physicians may offer palliative sedation to unconsciousness to address refractory clinical symptoms, not to respond to existential suffering arising from such issues as death anxiety, isolation, or loss of control. Existential suffering should be addressed through appropriate social, psychological, or spiritual support.

5.7 Physician-Assisted Suicide

Physician-assisted suicide occurs when a physician facilitates a patient’s death by providing the necessary means and/or information to enable the patient to perform the life-ending act (eg, the physician provides sleeping pills and information about the lethal dose, while aware that the patient may commit suicide).

It is understandable, though tragic, that some patients in extreme duress—such as those suffering from a terminal, painful, debilitating illness—may come to decide that death is preferable to life. However, permitting physicians to engage in assisted suicide would ultimately cause more harm than good.

Physician-assisted suicide is fundamentally incompatible with the physician’s role as healer, would be difficult or impossible to control, and would pose serious societal risks.

Instead of engaging in assisted suicide, physicians must aggressively respond to the needs of patients at the end of life. Physicians:

(a) Should not abandon a patient once it is determined that cure is impossible.

(b) Must respect patient autonomy.

(c) Must provide good communication and emotional support.

(d) Must provide appropriate comfort care and adequate pain control.
5.8 Euthanasia

Euthanasia is the administration of a lethal agent by another person to a patient for the purpose of relieving the patient’s intolerable and incurable suffering.

It is understandable, though tragic, that some patients in extreme duress—such as those suffering from a terminal, painful, debilitating illness—may come to decide that death is preferable to life.

However, permitting physicians to engage in euthanasia would ultimately cause more harm than good.

Euthanasia is fundamentally incompatible with the physician’s role as healer, would be difficult or impossible to control, and would pose serious societal risks. Euthanasia could readily be extended to incompetent patients and other vulnerable populations.

The involvement of physicians in euthanasia heightens the significance of its ethical prohibition. The physician who performs euthanasia assumes unique responsibility for the act of ending the patient’s life. Instead of engaging in euthanasia, physicians must aggressively respond to the needs of patients at the end of life.

Physicians:

(a) Should not abandon a patient once it is determined that a cure is impossible.
(b) Must respect patient autonomy.
(c) Must provide good communication and emotional support.
(d) Must provide appropriate comfort care and adequate pain control.

AMA Principles of Medical Ethics: I, IV
Issued: 1994
Opinions on Related Matters:
1.1.1 Patient-Physician Relationships
1.1.7 Physician Exercise of Conscience
2.1.1 Informed Consent
2.1.2 Decisions for Adult Patients Who Lack Capacity
5.6 Sedation to Unconsciousness in End-of-Life Care
5.7 Physician-Assisted Suicide
(d) Ensure that treatment recommendations for all patients are based on scientific evidence, relevant professional guidelines, sound professional judgment, and prudent stewardship.

(e) Uphold standards of honesty and transparency in billing and clearly distinguish charges for special services or amenities provided under a retainer contract from medical services reimbursable by the patient’s health care insurance or third-party payer.

(f) Uphold professional obligations to promote access to health care and to provide care to those in need regardless of ability to pay, in keeping with ethical guidelines.

### 11.3 Fees and Charges

**11.3.1 Fees for Medical Services**

Physicians are expected to conduct themselves as honest, responsible professionals. They should be knowledgeable about and conform to relevant laws and should adhere to professional ethical standards and sound business practice. Physicians should not recommend, provide, or charge for unnecessary medical services. Nor should they make intentional misrepresentations to increase the level of payment they receive or to secure noncovered health benefits for their patients.

With regard to fees for medical services, physicians should:

(a) Charge reasonable fees based on the:
   (i) kind of service(s);
   (ii) difficulty or uniqueness of the service(s) performed;
   (iii) time required to perform the service(s);
   (iv) skill required to perform the service(s);
   (v) experience of the physician;
   (vi) quality of the physician’s performance.

(b) Charge only for the service(s) that are personally rendered or for services performed under the physician’s direct personal observation, direction, or supervision. If possible, when services are provided by more than one physician, each physician should submit his or her own bill to the patient and be compensated separately. When physicians have professional colleagues assist in the performance of a service, the physician may pay a reasonable amount for such assistance and recoup that amount through fees charged to the patient, provided the patient is notified in advance of the financial arrangement.
(c) Itemize separately charges for diagnostic, laboratory, or clinical services provided by other health care professionals and indicate who provided the service when fees for others’ services cannot be billed directly to the patient, in addition to charges for the physician’s own professional services.

(d) Not charge excessive fees, contingent fees, or fees solely to facilitate hospital admission. Physicians must not charge a markup or commission, or profit on services rendered by other health care professionals.

(e) Extend professional courtesy at their discretion, recognizing that it is not an ethical requirement and is prohibited in many jurisdictions.

### 11.3.2 Fees for Nonclinical and Administrative Services

Physicians individually and collectively should promote access to care for individual patients, in part through being prudent stewards of resources. Thus, physicians have a responsibility to balance patients’ needs and expectations with responsible business practices.

With respect to fees for nonclinical or administrative services provided in conjunction with patient care, physicians should:

(a) Clearly notify patients in advance of fees charged by the practice (if any) for nonclinical or administrative services.

(b) Base fees (if any) on reasonable costs to the practice for:
   (i) providing special documentation on patient request for such purposes as insurance reimbursement to the patient, certification of immunization or fitness, or similar nonclinical services;
   (ii) missed appointments or appointments not cancelled in advance in keeping with the published policy of the practice;
   (iii) acquisition or processing charges in relation to diagnostic, laboratory, or clinical services, copies of medical records, or similar nonclinical services.

### 11.3.3 Interest and Finance Charges

Financial obstacles to medical care can directly affect patients’ well-being and may diminish physicians’ ability to use their knowledge and skills on patients’ behalf. Physicians should not be expected to risk the viability of their practices or compromise
The Code of Medical Ethics (Code) of the American Medical Association, consisting of the Principles of Medical Ethics and Opinions of the Council on Ethical and Judicial Affairs (CEJA) that interpret them, is an important source of guidance for responsible professional conduct. Together, the Principles and Opinions have served as the primary statement of the values to which physicians commit themselves as members of the medical profession.

The impact of the Code has been significant. Attorneys, judges, and scholars in medical ethics have looked to the Principles and Opinions for legal advocacy and decision making in health care. These Annotations are designed to provide a research and reference tool for practitioners, scholars, jurists, and others. Annotations summarize all reported court decisions and selected state attorney general opinions that make substantive reference to Principles or Opinions, as well as selected articles from the medical, legal, and ethics literature.

Each case annotation offers a synopsis of facts and legal issues, then focuses on the court’s reference to the Principle(s) or Opinion(s) and the role it played in the decision. Where necessary, each case annotation includes a cross-reference to the relevant provision(s) of the version of the Principles and Opinions as they appeared in the 2014-2015 edition of the Code. Note that the Annotations have not been updated for this edition of the Code.

Journal annotations provide a general summary of the subject article and indicate which specific Principle(s) or Opinion(s) the article references, with appropriate cross-reference to the Principle or Opinion as it appeared in the 2014-2015 edition of the Code. Each journal annotation indicates whether the article refers to the Principle or Opinion in a general way; specifically cites the Principle or Opinion; or directly quotes the language of the Principle or Opinion.

To facilitate efficient use of this resource, both case and journal annotations identify the specific page(s) where the Principle(s) or Opinion(s) are discussed. An Index of Cases and an Index of Articles are also provided to enhance the usefulness of this compendium.

The Principles and Opinions have a long and evolving history. Over time, some Principles and Opinions have been substantially amended or eliminated. Moreover, in 2008, CEJA launched an ambitious project to review each of the more than 200 individual Opinions included in the Code at that time. Over the course of nearly 8 years, with input from the member organizations represented in the AMA House of Delegates and other stakeholders, CEJA updated the Opinions to ensure that guidance remains relevant and consistent. CEJA reorganized the Opinions into more intuitive, topically based chapters and recast the guidance of each individual Opinion into a uniform format to make guidance easy to find and use. Annotations for each constituent opinion are presented here in sequence. Users are advised to carefully review the particular case or article under consideration with respect to the user’s specific interest. A Concordance maps the updated Opinions in the present volume to their predecessors in the 2014-2015 edition of the Code.

**Journal 1992** Considers the debate surrounding medical futility. Observes that this debate is encouraging reexamination of the nature of patient entitlement to medical care as well as the “ends of medicine.” References Opinions 2.20, 2.21, and 2.22. *Miles, Medical Futility, 20 Law Med. & Health Care 310, 311, 313 (1992).*

**Journal 1992** Explains how the “terminal condition” requirement in natural death acts may reduce the number of people who fall within the scope of coverage. Also indicates that omission of nutrition and hydration from the list of treatments that may be withdrawn limits patient choices. Quotes Opinion 2.20. References Opinion 2.22. Note, *State Natural Death Acts: Illusory Protection of Individuals’ Life-Sustaining Treatment Decisions, 29 Harvard J. Legis. 175, 186, 194, 195, 201 (1992).*


**Journal 1991** Examines the involvement of the legal system in end-of-life medical decision-making. Questions whether the law should intrude into the domain. Concludes that judges should become involved primarily to address the “terms of reconciliation” between physicians and patients. References Opinion 2.22. Flick, *The Due Process of Dying, 79 Cal. L. Rev. 1121, 1152 (1991).*

**Journal 1990** Finds that a vast majority of North Carolina nursing homes have written cardiopulmonary resuscitation policies, but that there is substantial variation among them. Concludes that such variations risk limiting or ignoring the personal rights of residents. References Opinions 2.20 and 2.22. Brunetti, Weiss, Studenski, & Clipp, *Cardiopulmonary Resuscitation Policies and Practices: A Statewide Nursing Home Study, 150 Arch. Intern. Med. 121, 122 (1990).*

### 5.5 Medically Ineffective Interventions

**Journal 2010** Discusses futility disputes where a patient’s surrogate wishes to prolong treatment that the physician deems medically ineffective, and the current lack of legal remedies to resolve them. Concludes that states need to establish fair, impartial, and patient-centered methods of resolving futility disputes including independent medical boards that would operate under procedural and substantive regulations. Quotes Opinions 2.02 and 2.035. References Opinions 2.17 and 2.20. *Bassel, Order at the End of Life: Establishing a Clear and Fair Mechanism for the Resolution of Futility Disputes, 63 Vand. L. Rev. 491, 494, 523 (2010).*

**Journal 2009** Examines criteria defining when renal dialysis becomes futile. Concludes that uniform guidelines should be adopted defining when medical care is futile and should be withheld. Cites Opinion 2.035. *Fink, Time to Stop Dialyzing the Dead (and Treating Other Patients Too Aggressively, Too), 38 Dialysis & Transplantation 184, 185 (May 2009, 1, 1).*

**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 2008** Discusses medical options when the physician can do nothing further to cure the patient and examines the Texas Advance Directives Act, a medical futility statute. Concludes conflicts may be reduced if physician-patient communication is initiated when treatment begins rather than when further treatment becomes futile. Cites the Texas medical futility process as an example for providing physicians a mechanism for resolving conflicts with patients. Quotes Opinions 2.035, 2.037, and 2.20. *Dahm, Medical Futility and the Texas Medical Futility Statute: A Model to Follow or One to Avoid? 20 Health Law 25, 26 (Aug. 2008).*

**Journal 2007** Argues that it is unethical for a physician to withhold CPR without seeking consent of the patient. Concludes that standards for withholding care should be agreed upon by society and passed into law. Cites Opinion 2.035. *Manthous, Counterpoint: Is It Ethical to Order “Do Not Resuscitate” Without Patient Consent? 132 Chest 751, 753 (2007).*

**Journal 2007** Compares US and international policy on end-of-life decision making. Concludes that interests of patient autonomy should be balanced with family interests and advocates a comprehensive “best interest” model.


**Journal 2004** Examines conflicts that arise when a hospice may be obligated to resuscitate a patient who has not executed an advance directive regarding CPR. Concludes that the Patient Self-Determination Act must be amended to allow hospice providers to administer CPR in only a limited number of circumstances. References Opinions 2.035 and 2.22. Rutkow, *Dying to Live: The Effect of the Patient Self-Determination Act on Hospice Care*, 7 N. Y. U. J. Legis. & Pub. Pol’y 393, 413, 430 (2004).


**Journal 2002** Discusses the precautions lawyers must take when advising clients about living wills. Concludes clients must be reminded that medical advances or changes in circumstances may affect their living wills. Quotes Opinion 2.035. Kruse, *A Call for New Perspectives for Living Wills (You Might Like It Here)*, 37 Real Prop., Prob. & Tr. J. 545, 550 (2002).

**Journal 2001** Observes that many aspects of managed care have increased the tensions between patients and their health care providers. Notes that patient dissatisfaction is on the rise for other reasons as well. Concludes that Congress should take a comprehensive legislative approach in addressing these issues. Quotes Opinion 2.17. Cites Opinion 2.035. References Opinions 2.037 and 2.22. Sanematsu, *Taking a Broader View of Treatment Disputes Beyond Managed
5.7 Physician-Assisted Suicide

U.S. 2006 State of Oregon brought suit seeking declaratory and injunctive relief from enforcement of an interpretive rule of a US Attorney General’s opinion, which stated that physicians who assist patients in suicide under the authority of the Oregon Death with Dignity Act (ODWDA) violate the federal Controlled Substances Act (CSA). The Ninth Circuit Court of Appeals found the rule invalid. Appeal to the Supreme Court followed. In affirming, the majority held that the interpretive rule is not entitled to deference and that the CSA does not allow the attorney general to prohibit physicians from prescribing drugs for use in assisted suicide pursuant to state law. Quoting Opinion 2.211, the dissent stated that assisted suicide is incompatible with a physician’s role as a healer and does not serve a legitimate medical purpose. Gonzales v. Oregon, 126 S. Ct. 904, 932.

U.S. 1997 Several physicians and terminally ill patients sued the state seeking a declaration that its prohibition against physician-assisted suicide violates the Fourteenth Amendment’s Equal Protection Clause. The trial court disagreed, but the Second Circuit reversed, holding that the state accords different treatment to those terminally ill patients who wish to hasten their death by self-administering prescribed drugs and to those patients who wish to do so by directly removing life support systems. The Supreme Court reversed holding that the prohibition against assisting suicide does not violate the Equal Protection Clause. The Court concluded that there is a distinction between assisting suicide and withdrawing treatment, quoting reports of the AMA Council on Ethical and Judicial Affairs [now Opinions 2.20 and 2.211], Vacco v. Quill, 117 S. Ct. 2293, 2298, 138 L. Ed. 2d 834.

U.S. 1997 Several Washington physicians, terminally ill patients, and a not-for-profit organization that counsels people considering physician-assisted suicide sued the state seeking to have statutory ban on physician-assisted suicide declared unconstitutional. The trial court agreed and the Ninth Circuit affirmed. The Supreme Court, in reversing the decision, held that prohibition against causing or aiding a suicide does not violate the Due Process Clause. The Court also noted that the prohibition was rationally related to legitimate state interests in protecting the integrity and ethics of the medical profession, quoting from Opinion 2.211. Washington v. Glucksberg, 117 S. Ct. 2258, 2273, 138 L. Ed. 2d 772.

9th Cir. 1996 Suit was brought by several physicians and a not-for-profit corporation which provides information, assistance, and counseling to competent terminally ill adult patients contemplating suicide, asserting that a state statute making it a crime to aid anyone in attempting to commit suicide unconstitutionally prevents terminally ill patients from exercising their protected liberty interests. Appeals court, en banc, held that the choice of how and when to die is a liberty interest and that the statute violates the due process rights of competent, terminally ill adults who wish to hasten their deaths by obtaining medication prescribed by their physicians. Stating that physician-assisted suicide runs counter to medical ethics, the dissent cited Opinions 2.20, 2.21, and 2.211 and quoted Opinion 2.211. Compassion in Dying v. Washington, 79 F.3d 790, 840, 855 replacing, 49 F.3d 586 (9th Cir. 1995).

9th Cir. 1995 A not-for-profit corporation organized to assist terminally ill persons in committing suicide and several physicians alleged that a state statute making aiding a suicide attempt a crime violated 42 USC § 1983 and the Constitution. In upholding the statute, the court quoted Opinion 2.211 as articulating the ethical position of the medical profession against assisted suicide. In turn, the court found upholding the ethical integrity of the medical profession to be one of the many state interests outweighing the alleged liberty interest in medically assisted suicide. Compassion in Dying v. Washington, 49 F.3d 586, 592, replaced, 79 F.3d 790 (9th Cir. 1996).

Alaska 2001 Two mentally competent, terminally ill adults filed suit, asking the superior court to declare Alaska’s manslaughter statute invalid so that their physicians could assist them in committing suicide. The superior court entered summary judgment against the patients and the Alaska Supreme Court affirmed. In concluding that Alaska’s constitutional rights of privacy and liberty do not afford terminally ill patients the right to a physician’s assistance in committing suicide, the court quoted Opinion 2.211 in support of the state’s interest in protecting the integrity of the medical profession. Sampson v. State, 31 P.3d 88, 96, 97.

Fla. 1997 A patient, suffering from acquired immune deficiency syndrome (AIDS), and his physician filed suit for a declaratory judgment that state law prohibiting assisted suicide violated the privacy clause of the state constitution, as well as the due process and equal protection clauses of the Fourteenth Amendment to the US Constitution. The trial court concluded that the law was unconstitutional. On appeal the state Supreme Court, relying on the US Supreme Court’s rulings in Washington v. Glucksberg, 117 S.Ct. 2258 (1997) and Vacco v. Quill, 117 S.Ct. 2293 (1997), held that the state’s ban was not unconstitutional. In determining that the right to assisted suicide is not included in the state’s guarantee of privacy, the court quoted from Opinion 2.211. Krischer v. McIver, 697 So. 2d 97, 103.

Mich. App. 2001 State brought criminal action against physician for the murder of a patient by lethal injection. The trial court convicted the physician of second-degree murder and delivering a controlled substance. On appeal, the trial court decision was affirmed. The physician asked the appellate court to conclude that euthanasia is legal and to reverse his conviction on constitutional grounds. The appellate court relied on Washington v. Glucksberg, 521 U.S. 702 (1997) in determining there is no constitutional right to commit euthanasia, so that an individual can be free from intolerable and irremediable suffering. In discussing Glucksberg, the court observed that a state has a legitimate interest in protecting
To aid readers in navigating the updated *Code of Medical Ethics*, the Concordance below maps previous Opinion numbers and titles of the 2014-2015 edition to their new, updated numbers and titles in this 2016 edition.

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The cases below cross-reference the relevant provision(s) of the version of the Principles and Opinions as they appeared in the 2014-2015 edition of the Code of Medical Ethics (Code). The Concordance maps the updated Opinions in the present volume to their predecessors in the 2014-2015 edition of the Code.

A Woman's Choice-East Side Women's Clinic v. Newman, 305 F.3d 684 (7th Cir. 2002) [8.08].
Acuna v. Turkish, 192 N.J. 399, 930 A.2d 416 (2007) [8.08].
Allen v. Smith, 368 S.E.2d 924 (W. Va. 1988) [IV].
Amaral v. Saint Cloud Hospital, 598 N.W.2d 379 (Minn. 1999) [V].
American Medical Ass’n v. FTC, 638 F.2d 443, (2nd Cir. 1980), aff’d, 455 US 676 (1982) [5.02, 8.05].
American Medical Ass’n v. United States, 130 F.2d 233 (D.C. Cir. 1942), aff’d, 317 US 519 (1943) [8.05].
American Optometric Ass’n v. F.T.C., 626 F.2d 896 (D.C. Cir. 1980) [5.02].
Anderson v. Florence, 288 Minn. 351, 181 N.W.2d 873 (1970) [II; 8.12].
Arizona State Bd. of Medical Examiners v. Clark, 97 Ariz. 205, 398 P.2d 908 (1965) [III, VII; 3.01, 8.11, 9.06].
Arroyo v. United States, 656 F.3d 663, 678 (7th Cir. 2011) [8.12].
Awwad v. Capital Region Otolaryngology Head & Neck Group, 2007 N.Y. Misc. LEXIS 8593 [9.02].
Balian v. Board of Licensure in Medicine, 722 A.2d 364 (Me. 1999) [7.01, 7.02].
Bay Ridge Diagnostic Laboratory, Inc. v. Dumpson, 400 F. Supp. 1104 (E.D.N.Y. 1975) [8.03, 8.032, 8.06, 9.06].
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<td>2 J. Trial App. Advoc.</td>
<td>105, 107 (1997)</td>
<td>[IV]</td>
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