

Review of the American College of Physicians Ethics Manual, Sixth Edition

Medical ethics is coeval with medical practice. As the mere existence of the Hippocratic Oath and other ancient medical codes attest, the ethical norms of proper conduct need to be defined whenever sick and vulnerable people are cared for. These norms usually address the nature and limits of the physician–patient relationship; truth-telling; informed consent; confidentiality; sexual relationships with patients; and balancing the interests of patients, their families, and the community. Remarkably, over millennia these codes arrive at similar recommendations. The American College of Physicians (ACP) Ethics Manual, published as a supplement to this issue (1), is an integral part of an ancient tradition.

Ethical pronouncements by official bodies tend to be prosaic. Frequently, this is because acceptable conduct in the face of many ethical dilemmas depends on the particular circumstances; thus, precise general recommendations would be inappropriate. On occasion, banal exhortations in ethical codes are an attempt to conceal controversy with diplomatic vagueness. Not surprisingly, many of the recommendations in the Ethics Manual are hemmed with qualifications: “when appropriate,” “when necessary,” “when the law requires it,” “routinely,” “in some circumstances,” or “seek consultation from colleagues.” Some may even seem to border on vacuous: “The physician must respect the dignity of all persons and respect their uniqueness.”

However, what is truly amazing is that the Ethics Manual contains so many clear and specific recommendations. On execution, interrogation, and torture, the ACP Ethics, Professionalism, and Human Rights Committee is definitive and absolute. Indeed, it specifies not only negative duties but positive ones as well:

Participation by physicians in the execution of prisoners except to certify death is unethical.

Physicians must not conduct, participate in, monitor, or be present at interrogations. . . .

Physicians must not be a party to and must speak out against torture. . . .

The format of the Ethics Manual does not permit elaborate ethical justifications, but presumably these unconditional imperatives are based on the logic that physicians’ primary obligation is to promote their patients’ health and well-being. Execution, interrogation, and torture never promote a patient’s health or well-being. Hence, a physician must never participate in these activities.

Even more important is the Ethics Manual’s statements related to the practice environment. The Committee

observes that physicians have obligations to society. This corresponds to the American Medical Association’s ethical principle that states “a physician must recognize responsibility to patients first and foremost, as well as to society, to other health professionals, and to self” (2). But then the ACP Committee elaborates a very significant obligation:

Physicians have a responsibility to practice effective and efficient health care and to use health care resources responsibly. Parsimonious care that utilizes the most efficient means to effectively diagnose a condition and treat a patient respects the need to use resources wisely. . . .

Most physicians were inculcated that ideal physicians are thorough, comprehensive, and exhaustive in their work-ups and treatments—and ignore costs in the process. Here is an authoritative medical body using such words as “efficient” and “parsimonious”—and without “qualifications”—to describe the ideal physician’s practices. And to be sure it is not missed, this statement is placed in a “call-out” box. This is truly remarkable. To delineate what this means in practical terms, the Manual further specifies that “physicians’ considered judgments should reflect the best available evidence in the biomedical literature, including data on the cost-effectiveness of different clinical approaches.” Here is a professional society unafraid of advocating the principle of cost-effectiveness.

These positions on efficiency, parsimony, and cost-effectiveness constitute an important shift, if not in ethics then in emphasis. The challenge is for this philosophy to diffuse from the professional society to practitioners so that the sign of a good physician is not the one who delineates and chases every possible “zebra” in the differential diagnosis, raising costs with no concern.

In another section, the Committee recognizes that physicians have a “professional obligation” to care for the poor and that “all physicians should provide services to uninsured and underinsured persons.” How much care does each physician have to provide? The Committee contends that “each individual physician is obliged to do his or her fair share. . . .” While “fair share” is vague, it is certainly not zero. This may suggest a new requirement for physician licensure: documentation of some pro bono care of the poor by each practitioner. This is another important and strong ethical statement.

Inevitably, such an extensive manual will not get every recommendation right, and this document includes some problematic statements. The most obvious ones are found in new entries related to research. For instance, the Committee endorses the Declaration of Helsinki’s position on using placebo controls even though this view is highly con-

controversial and pretty definitively discredited (3, 4). Similarly, regarding research with stored biospecimens, the Committee recommends that “[r]esearch subjects should be informed of plans to pool or otherwise share biologic material.” The justification for this recommendation is unclear, because many studies show that research participants do not want to make such choices. What participants want is the option to consent to their biospecimens being made available for research or not. Approximately 85% to 90% are willing to have their specimens used for research. Beyond that, data from thousands of participants indicate that they do not want to address questions about who uses the samples, for what types of research, and with what research techniques or methods (5).

The Committee also argues that “physician-investigators should disclose this conflict to potential research participants. . . .” If the research protocol fulfills all ethical requirements, it is unclear that disclosure of being both a physician and a researcher is appropriate much less necessary. These controversial areas will probably generate the kind of debate the Manual calls for.

Another section of the Manual that will probably generate debate involves physician–industry relationships. The Ethics Manual states that “[t]he acceptance by a physician of gifts, hospitality, trips, and subsidies of all types from the health care industry that might diminish, or appear to others to diminish, the objectivity of professional judgment is strongly discouraged.” Many will question why the ACP strongly discourages such gifts rather than prohibits them outright. Indeed, if the gifts diminish or appear to diminish judgment, they must be prohibited to maintain the integrity of the physician and the profession.

Furthermore, the Ethics Manual relies heavily on disclosure to address ethical issues. For instance, why “physicians should disclose their potential conflicts of interests to their patients” rather than have those conflicts prohibited is unclear. Sick and vulnerable patients are unlikely to be in a position to address those conflicts, and research suggests that they are not inclined to want the disclosures but rather to have a system that “solves” the problem for them.

Conversely, sometimes the recommendation to disclose seems too limited. The Ethics Manual states that

“[t]rainees should inform the patient of their level of experience with any procedures that they are performing on the patient.” Why is this recommendation limited to trainees? Practicing physicians are frequently learning new techniques for which experience and competence are clearly correlated. Why should practicing urologists, for instance, not be required to disclose to patients how many robotic prostatectomies they have performed?

Despite and perhaps in part because of the questions it raises, the ACP Ethics Manual is an important guide for physicians. It goes well beyond the usual banalities to take brave stands on current issues. Doubtless, some of its provisions will be discussed and debated and others will be refined in the next edition. Yet, this document is a worthy heir to the tradition of medical oaths and codes that stretches back millennia.

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