PRINCIPLES OF MEDICAL ETHICS and OPINIONS & REPORTS OF THE JUDICIAL COUNCIL

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PRINCIPLES OF MEDICAL ETHICS

AND

OPINIONS AND REPORTS OF THE JUDICIAL COUNCIL

OF THE

WASHINGTON STATE MEDICAL ASSOCIATION

PREFACE

This edition of the Opinions and Reports of the Judicial Council of the Washington State Medical Association replaces all previous editions which were last published in 2001. It is intended as an adjunct to the revised Principles of Medical Ethics that were adopted by the American Medical Association in 2001 and by the House of Delegates of the Washington State Medical Association in 2005.

Medical ethics involves the professional responsibilities and obligations of physicians. The Opinions expressed by the Judicial Council are intended as guidelines to responsible professional behavior, but they are not presented as the sole or only route to medical morality.

An attempt is made to relate the Judicial Council's Opinions to relevant Principles of Medical Ethics in the parentheses at the end of each Opinion. However, no one Principle can stand alone or be individually applied to a situation. In all instances, it is the conglomerate intent and influence of the Principles of Medical Ethics which shall measure ethical behavior for the physician. Judicial Council Opinions are issued under the Council's authority to interpret the Principles of Medical Ethics and to investigate general ethical conditions in all matters pertaining to the relations of physicians to one another and to the public.

The Judicial Council encourages comments and suggestions for future editions of its Opinions and Reports.

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WASHINGTON STATE MEDICAL ASSOCIATION

PRINCIPLES OF MEDICAL ETHICS

As adopted by the 2005 WSMA House of Delegates
from the 2001 AMA Principles of Medical Ethics

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

I. A physician shall be dedicated to providing competent medical 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.

WASHINGTON STATE MEDICAL ASSOCIATION

JUDICIAL COUNCIL OPINIONS -- 2005

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WASHINGTON STATE MEDICAL ASSOCIATION

JUDICIAL COUNCIL OPINIONS

October 2005

1.00 INTRODUCTION

1.01 TERMINOLOGY.

Historically, the term "ethical" has been used in opinions of the Judicial Council and in resolutions adopted by the House of Delegates to refer to matters involving: 1) moral principles or practices; 2) customs and usages of the medical profession; and 3) matters of policy not necessarily involving issues of morality in the practice of medicine. The term "unethical" has been used to refer to conduct which fails to conform to these professional standards, customs and usages, or policies.

Unethical conduct involving moral principles, values, and duties calls for disciplinary action such as censure, suspension, or expulsion from medical society membership.

Failure to conform to the customs and usages of the medical profession may call for disciplinary action depending upon the particular circumstances involved, local attitudes, and how the conduct in question may reflect upon the dignity of and respect for the medical profession.

In matters strictly of a policy nature, a physician who disagrees with the position of the Washington State Medical Association is entitled to freedom and protection of his point of view.

1.02 THE RELATION OF LAW AND ETHICS.

The following statements are intended to clarify the interrelationship between law and ethics.

Ethical standards of professional conduct and responsibility may exceed but are never less than nor contrary to, those required by law.

Violation of governmental laws may subject the physician to civil or criminal liability. Expulsion from membership is the maximum penalty that may be imposed by a medical society upon a physician who violates the ethical standards involving a breach of moral duty or principle. However, medical societies have a civic and

professional obligation to report to the appropriate governmental body or state board of medical examiners credible evidence that may come to their attention involving the alleged criminal conduct of any physician relating to the practice of medicine.

Although a physician charged with allegedly illegal conduct may be acquitted or exonerated in civil or criminal proceedings, this does not discharge a medical society from its obligation to initiate a disciplinary proceeding against a member with reference to the same conduct where there is credible evidence tending to establish unethical conduct.

Ethical pronouncements of the Judicial Council and the House of Delegates should not be so interpreted, construed, or applied as to encourage conduct which violates a valid law.

2.00 OPINIONS ON SOCIAL POLICY ISSUES

2.01 ABORTION. The principles of Medical Ethics of the Washington State Medical Association do not prohibit a physician from performing an abortion in accordance with good medical practice and under circumstances that do not violate the law. (IV)

2.02 ABUSE OF CHILDREN, ELDERLY PERSONS, AND OTHERS AT RISK. Laws that require the reporting of cases of suspected abuse of children and elderly persons often create a difficult dilemma for the physician. The parties involved, both the suspected offenders and the victims, will often plead with the physician that the matter be kept confidential and not be disclosed or reported for investigation by public authorities.

Children who have been seriously injured, apparently by their parents, may nevertheless try to protect their parents by saying that the injuries were caused by an accident, such as a fall. The reason may stem from the natural parent-child relationship or fear of further punishment. Even institutionalized elderly patients who have been physically maltreated may be concerned that disclosure of what has occurred might lead to further and more drastic maltreatment by those responsible.

The physician who fails to comply with the laws requiring reporting of suspected cases of abuse to children and elderly persons and others at risk can expect that the victims could receive more severe abuse that may result in permanent bodily or brain injury or even death.

Public officials concerned with the welfare of children and elderly persons have expressed the opinion that the incidence of physical violence to these persons is rapidly increasing and that a very substantial percentage of such cases is unreported by hospital personnel and physicians. An important element that is sometimes overlooked is that a child or elderly person brought to a physician with a suspicious injury is the patient whose interests require the protection of law in a particular situation, even though the physician may also provide services from time to time to parents or other members of the family.

The obligation to comply with statutory requirements is clearly stated in the Principles of Medical Ethics. As stated in 1.02, the ethical obligation of the physician may exceed the statutory legal requirement. (I, III)

2.03 ALLOCATION OF HEALTH RESOURCES. A physician has a duty to do all that he can for the benefit of his individual patients without assuming total responsibility for equitable disbursement of society's limited health resources. To expect a physician in the context of his medical practice to administer governmental priorities in the allocation of scarce health resources is to create a conflict with the physician's primary responsibility to his patients that would be socially undesirable.

Limited health care resources should be allocated efficiently and on the basis of fair, acceptable, and humanitarian criteria. Priority should be given to persons who are most likely to be treated successfully or have long-term benefit. Social worth is not an appropriate criterion.

Utility or relative worth to society should not determine whether an individual is accepted as a donor or recipient of tissue for transplantation, selected for human experimentation, or denied or given preference in receiving scarce health care treatment or resources. (I)

2.04 ARTIFICIAL INSEMINATION. The informed consent of the woman seeking artificial insemination and her husband is necessary. The prospective parents should be informed that any child conceived by artificial insemination is possessed of and entitled to all the rights of a child conceived naturally. (I, V)

2.05 ARTIFICIAL INSEMINATION BY DONOR. The ethical issues in the procedure of human artificial insemination are the same as in any other medical or surgical procedure. The nature of the procedure requires emphasis of: 1) the importance of the concern the physician must have for his patient, her spouse, and the child which

may result from the procedure; 2) the need for consent arrived at intellectually rather than emotionally; 3) the competence of the physician who assumes this unique responsibility; and 4) the need for preservation of confidentiality by the physician and his staff.

Even as the physician shows concern for the woman and her desire for motherhood, he must ensure that emotions do not adversely affect those judgments which must be sound and reasoned. The consent of both the woman seeking the procedure and her husband must be secured. This consent must be voluntary and informed.

Physicians without special knowledge and competence in the field should refrain from engaging in the procedure. It must be remembered by the physician and explained by him to the prospective parents that any child conceived and born of an artificial insemination is possessed of and entitled to all rights of a child conceived naturally.

The utmost medical secrecy by the attending physician and his entire staff is essential in all aspects of the procedure. All medical records regarding the procedure must be securely protected from invasion.

Since the identity of donors usually should not be available to recipients or the offspring that may result, the risk of inadvertent inbred and serious undesirable genetic and biological consequences should not be ignored. Physicians have an ethical and social responsibility to avoid the frequent use of semen from the same sources. (I, V)

2.06 CAPITAL PUNISHMENT. An individual's opinion on capital punishment is the personal moral decision of the individual. A physician is a member of a profession dedicated to preserving life when there is hope of doing so. As such, it is the opinion of the WSMA Judicial Council that participation in a legally authorized execution be discouraged. A physician may make a determination or certification of death as currently provided by law in any situation.

2.07 CLINICAL INVESTIGATION. The following guidelines are intended to aid physicians in fulfilling their ethical responsibilities when they engage in the clinical investigation of new drugs and procedures.

1) A physician may participate in clinical investigation only to the extent that those activities are a part of a systematic program competently designed, under accepted standards of scientific research, to produce data which are scientifically valid and significant.

2) In conducting clinical investigation, the investigator should demonstrate the same concern and caution for the welfare, safety, and comfort of the person involved as is required of a physician who is furnishing medical care to a patient independent of any clinical investigation.

3) In clinical investigation primarily for treatment --

A. The physician must recognize that the physician-patient relationship exists and that professional judgment and skill must be exercised in the best interest of the patient.

B. Voluntary written consent must be obtained from the patient, or from his legally authorized representative if the patient lacks the capacity to consent, following: a) disclosure that the physician intends to use an investigational drug or experimental procedure; b) a reasonable explanation of the nature of the drug or procedure to be used, risks to be expected, and possible therapeutic benefits; c) an offer to answer any inquiries concerning the drug or procedure; and d) a disclosure of alternative drugs or procedures that may be available.

i) In exceptional circumstances and to the extent that disclosure of information concerning the nature of the drug or experimental procedure or risks would be expected to materially affect the health of the patient and would be detrimental to his best interests, such information shall be disclosed to a responsible relative or friend of the patient where possible.

ii) Ordinarily, consent should be in writing, except where the physician deems it necessary to rely upon consent in other than written form because of the physical or emotional state of the patient.

iii) Where emergency treatment is necessary, the patient is incapable of giving consent, and no one is available who has authority to act on his behalf, consent is assumed.

4) In clinical investigation primarily for the accumulation of scientific knowledge --

A. Adequate safeguards must be provided for the welfare, safety, and comfort of the subject. It is fundamental social policy that the advancement of scientific knowledge must always be secondary to primary concern for the individual.

B. Consent, in writing, should be obtained from the subject, or from his legally authorized representative if the subject lacks the capacity to consent, following: a) a disclosure of the fact that an investigational drug of procedure is to be used; b) a reasonable explanation of the nature of the procedure to be used and risks to be expected; and c) an offer to answer any inquiries concerning the drug or procedure.

C. Minors or mentally incompetent persons may be used as subjects only if:

i) The nature of the investigation is such that mentally competent adults should not be suitable subjects.

ii) Consent, in writing, is given by a legally authorized representative of the subject under circumstances in which an informed and prudent adult would reasonably be expected to volunteer himself or his child as a subject.

D. No person may be used as a subject against his will.

E. The overuse of institutionalized persons in research is an unfair distribution of research risks. Participation is coercive and not voluntary if the participation is subjected to powerful incentives and persuasion. (I, III, V)

2.08 COSTS. While physicians should be conscious of costs and not provide or prescribe unnecessary services or ancillary facilities, social policy expects that concern for the care the patient receives will be the physician's first consideration. This does not preclude the physician, individually or through medical organizations, from participating in policy-making with respect to social issues affecting health care. (I, VII)

2.09 FETAL RESEARCH GUIDELINES. The following guidelines are offered as aids to physicians when they are engaged in fetal research:

1) Physicians may participate in fetal research when their activities are part of a competently designed program, under accepted standards of scientific research, to produce data which are scientifically valid and significant.

2) If appropriate, properly performed clinical studies on animals and nongravid humans should precede any particular fetal research project.

3) In fetal research projects, the investigator should demonstrate the same care and concern for the fetus as a physician providing fetal care or treatment in a non-research setting.

4) All valid federal or state legal requirements should be followed.

5) There should be no monetary payment to obtain any fetal material for fetal research projects.

6) Competent peer review committees, review boards, or advisory boards should be available, when appropriate, to protect against the possible abuses that could arise in such research.

7) Research on the so-called "dead fetus", macerated fetal material, fetal cells, fetal tissue, fetal organs, or the placenta should be in accord with state laws on autopsy and state laws on organ transplantation or anatomical gifts. Informed and voluntary consent, in writing, should be obtained from a legally authorized representative of the fetus.

8) In fetal research primarily for treatment of the fetus:

   A. Voluntary and informed consent, in writing, should be given by the gravid woman, acting in the best interest of the fetus.

   B. Alternative treatment or methods of care, if any, should be carefully evaluated and fully explained. If simpler and safer treatment is available it should be pursued.

9) In research primarily for treatment of the gravid female:

   A. Voluntary and informed consent, in writing, should be given by the patient.

   B. Alternative treatment or methods of care should be carefully evaluated and fully explained to the patient. If simpler and safer treatment is available, it should be pursued.

C. If possible, the risk to the fetus should be the least possible, consistent with the gravid female's need for treatment.

10) In fetal research involving a viable fetus, primarily for the accumulation of scientific knowledge:

A. Voluntary and informed consent, in writing, should be given by the gravid woman under circumstances in which a prudent and informed adult would reasonably be expected to give such consent.

B. The risk to the fetus imposed by the research should be the least possible.

C. The purpose of research is the production of data and knowledge which are scientifically significant and which cannot otherwise be obtained.

D. In this area of research, it is especially important to emphasize that care and concern for the fetus should be demonstrated. There should be no physical abuse of the fetus. (I, III, V)

2.10 GENETIC COUNSELING. Two primary areas of genetic diagnosis are: 1) screening or evaluating prospective parents before conception for genetic disease to predict the likelihood of conceiving an affected child; and 2) in utero testing after conception, such as ultrasonography, amniocentesis, and fetoscopy, to determine the condition of the fetus. Physicians engaged in genetic counseling are ethically obligated to provide prospective parents with the basis for an informed decision for childbearing. In providing information to couples who choose to reproduce, physicians should adhere to the Principles of Medical Ethics and standards of medical practice.

Technological developments in the accuracy of predicting and detecting genetic disorders have created a dilemma for the physician who for personal reasons opposes contraception, sterilization, or abortion. The physician should be aware that where a genetic defect is found in the fetus, prospective parents may request or refuse an abortion. A dilemma may also exist for physicians who do not oppose the provision of these services (contraception, sterilization, or abortion).

Physicians who consider the legal and ethical requirements applicable to genetic counseling to be in conflict with their moral values and conscience may choose to limit such services to preconception diagnosis and advice or not provide any genetic

services. However, there are circumstances in which the physician who is so disposed is nevertheless obligated to alert prospective parents that a potential genetic problem does exist, that the physician does not offer genetic services, and that the patient should seek medical genetic counseling from another qualified specialist.

Physicians, whether they oppose or do not oppose contraception, sterilization, or abortion, may decide that they can engage in genetic counseling and screening but should avoid the imposition of their personal moral values and the substitution of their own moral judgment for that of the prospective parents. (II, IV, V, VI)

2.11 GENETIC ENGINEERING. Whatever form of regulation of gene splicing, recombinant DNA research, chemical synthesis of DNA molecules, or other genetic engineering research is eventually developed, there should be independent input from the scientific community, organized medicine, industry, and others, in addition to the federal government, to prevent abuse from any sector of society, private or public.

If and when gene replacement with normal DNA becomes a practical reality for the treatment of human disorders, the following factors should be considered:

1) If procedures are performed in a research setting, reference should be made to the Judicial Council's guidelines on clinical investigation.

2) If procedures are performed in a non-research setting, adherence to usual and customary standards of medical practice and professional responsibility would be required.

3) Full discussion of the proposed procedure with the patient would be required. The consent of the patient or his legal representative should be informed, voluntary, and written.

4) There must be no hazardous or other unwanted virus on the viral DNA containing the replacement or corrective gene.

5) The inserted DNA must function under normal control within the recipient cell to prevent metabolic damage that could damage tissue and the patient.

6) The effectiveness of the gene therapy should be evaluated as best as possible. This will include determination of the natural history of the disease and follow-up examination of subsequent generations.

7) Such procedures should be undertaken in the future only after careful evaluation of the availability and effectiveness of other possible therapy. If simpler and safer treatment is available, it should be pursued.

8) These considerations should be reviewed, as appropriate, as procedures and scientific information are developed in the future. (I, V, VII)

2.12 ORGAN TRANSPLANTATION GUIDELINES. The following statement is offered for guidance of physicians as they seek to maintain the highest level of ethical conduct in the transplanting of human organs.

1) In all professional relationships between a physician and his patient, the physician's primary concern must be the health of his patient. He owes the patient his primary allegiance. This concern and allegiance must be preserved in all medical procedures, including those which involve the transplantation of an organ from one person to another where both donor and recipient are patients. Care must, therefore, be taken to protect the rights of both the donor and the recipient, and no physician may assume a responsibility in organ transplantation unless the rights of both donor and recipient are equally protected.

2) A prospective organ transplant offers no justification for a relaxation of the usual standard of medical care. The physician should provide his patient, who may be a prospective organ donor, with that care usually given others being treated for a similar injury or disease.

3) When a vital, single organ is to be transplanted, the death of the donor shall have been determined by at least one physician other than the recipient's physician. Death shall be determined by the clinical judgment of the physician. In making this determination, the ethical physician will use currently accepted and available scientific tests.

4) Full discussion of the proposed procedure with the donor and the recipient or their responsible relatives or representatives is mandatory. The physician should be objective in discussing the procedure, in disclosing known risks and possible hazards, and in advising of the alternative procedures available. The physician should not encourage expectations beyond those which the circumstances justify. The physician's interest in advancing scientific knowledge must always be secondary to his primary concern for the patient.

5) Transplant procedures of body organs should be undertaken: a) only by physicians who possess special medical knowledge and technical competence developed through special training, study, and laboratory experience and practice; and b) in medical institutions with facilities adequate to protect the health and well-being of the parties to the procedure.

6) Transplantation of body organs should be undertaken only after careful evaluation of the availability and effectiveness of other possible therapy. (I, III, V)

2.13 PHYSICIANS AND FAMILY VIOLENCE: ETHICAL CONSIDERATIONS.

Family Violence: Because of its prevalence and medical consequences, abuse must be considered by physicians in the differential diagnosis for a number of medical complaints, particularly when treating women, children, and elderly persons.

Physicians who are likely to have the opportunity to detect abuse in the course of their work have an obligation to familiarize themselves with (1) protocols for diagnosing and treating family violence, (2) state reporting requirements and protective services, and (3) community resources for victims of abuse.

Physicians also have a duty to be aware of societal misconceptions about family violence and prevent these from affecting the diagnosis and management of abuse. Such misconceptions include the belief that abuse is a rare occurrence; that "normal" individuals are not abusive; that family violence is a private problem best resolved without outside interference; and that victims are responsible for abuse.

The medical profession must demonstrate to ending family violence and helping its victims. Physicians must play an active role in advocating increased services for victims and abusers. Protective services for abused children and elders need to be better funded and staffed, and follow-up services should be expanded. Shelters and safe homes for battered women and their children must be expanded and better funded. Mechanisms to coordinate the range of services, such as legal aid, employment services, welfare assistance, daycare, and counseling, should be established in every community. Mandatory arrest of abusers and greater enforcement of protection orders are important law enforcement reforms that should be expanded to more communities. There should be more research into the effectiveness of rehabilitation and prevention programs for abusers.

Informed consent for intervention should be obtained from competent victims of abuse. For minors who are not deemed mature enough to give informed consent, consent for emergency interventions need not be obtained from their parents.

Physicians can obtain authorization for further interventions from a court order or a court appointed guardian.

Physicians should inform patients of a child abuse diagnosis and they should inform an elderly patient's representative when the patient clearly does not possess the capacity to make health care decisions. Safety of the child or elderly person must be ensured prior to disclosing the diagnosis when the parents or caretakers are potentially responsible for the abuse. For competent adult victims, physicians must not disclose an abuse diagnosis to care givers, spouses or other third party without the consent of the patient.

2.14 PHYSICIANS AND INFECTIOUS DISEASES. A physician who knows that he or she has an infectious disease should not engage in any activity that creates a risk of transmission of the disease to others.

A physician may not ethically refuse to treat a patient whose condition is within the physician's current realm of competence solely because the patient is seropositive. Persons who are seropositive should not be subjected to discrimination based on fear or prejudice.

Physicians are dedicated to providing competent medical service with compassion and respect for human dignity.

Physicians who are unable to provide the services required by AIDS patients should make referrals to those physicians or facilities equipped to provide such services.

Physicians are ethically obligated to respect the rights of privacy and of confidentiality of AIDS patients and seropositive individuals.

Where there is no statute that mandates or prohibits the reporting of seropositive individuals to public health authorities and a physician knows that a seropositive individual is endangering a third party, the physician should: 1) attempt to persuade the infected patient to cease endangering the third party; 2) if persuasion fails, notify authorities; and 3) if authorities take no action, notify the endangered third party.

A physician who has AIDS or who is seropositive should consult colleagues as to which activities the physician can pursue without creating a risk to patients.

2.15 QUALITY OF LIFE. In the making of decisions for the treatment of seriously deformed newborns or persons who are severely deteriorated victims of injury, illness, or advanced age, the primary consideration should be what is best for the

individual patient and not the avoidance of a burden to the family or to society. Quality of life is a factor to be considered in determining what is best for the individual. Life should be cherished despite disabilities and handicaps, except when the prolongation would be inhumane and unconscionable. Under these circumstances, withholding or removing life supporting means is ethical provided that the normal care given an individual who is ill is not discontinued.

In desperate situations involving newborns, the advice and judgment of the physician should be readily available, but the decision whether to exert maximal efforts to sustain life should be the choice of the parents. The parents should be told the options, expected benefits, risks, and limits of any proposed care; how the potential for human relationships is affected by the infant's condition; and relevant information and answers to their questions. The presumption is that the love which parents usually have for their children will be dominant in the decisions which they make in determining what is in the best interest of their children. It is to be expected that parents will act unselfishly, particularly where life itself is at stake. Unless there is convincing evidence to the contrary, parental authority should be respected. (I, III, IV, V)

2.16 SECRET REMEDIES. It is unethical for a physician to prescribe, dispense, administer, or promote the use of any drug whose content or effect are unknown to him or to refuse to inform the patient (or his legal representative) about the identity and purpose of any drug which he has prescribed, dispensed, or administered to the patient.

2.17 TERMINAL ILLNESS. The social commitment of the physician is to prolong life and relieve suffering. Where the observance of one conflicts with the other, the physician, patient, and/or family of the patient have discretion to resolve the conflict.

For humane reasons, with informed consent a physician may do what is medically necessary to alleviate severe pain, or cease or omit treatment, including nutrition and hydration by other than normal natural methods, to let a terminally ill patient die, but he should not intentionally cause death. In determining whether the administration of potentially life-prolonging medical treatment is in the best interest of the patient, the physician should consider what the possibility is for extending life under humane and comfortable conditions and what are the wishes and attitudes of the family or those who have responsibility for the custody of the patient.

Where a terminally ill patient's coma is beyond doubt irreversible and there are adequate safeguards to confirm the accuracy of the diagnosis, all means of life

support may be discontinued. If death does not occur when life support systems are discontinued, the comfort and dignity of the patient should be maintained.

In arriving at decisions involving the withholding or withdrawing of invasive or extraordinary means, the physician should have informed involvement of the patient or the patient's family or guardian and further involvement of consultants, clergy, social workers, or nurses is desirable. (I, III, IV, V)

2.17.2 NO CODES. The development of cardio-pulmonary resuscitation (CPR) has led to "code" signals which summon immediately skilled personnel and sophisticated equipment in the event of sudden cessation of vital organs. The lifesaving impact of these teams is generally accepted. In many instances, however, the use of CPR can be contrary to the case of a patient with terminal cancer, or a patient dying of advanced cerebrovascular disease, or an aged patient who has asked to be allowed to die peacefully, the use of "code" can be harsh, unkind, and indecent. It also may lead to serious physical harm and to severe cerebral injuries. The training and reflexes of nursing personnel in hospitals and nursing homes lead them to call "code" in all cases of sudden death. They should not be expected to decide on whom the "code" should not be used. This is the prerogative and duty of the physician. In the opinion of the Judicial Council, should the physician consider "code" harmful to his patient's best interest, it is necessary that the physician so inform the charge nurse and sign the nurse's order card, or write the order as any other order. His decision shall be guided and reinforced by consultation with the family of the patient, and where appropriate, consulting physicians, nurses, clergy, or attorney.

Recommended guidelines for "code/no code" orders have been adopted jointly by the Washington State Medical Association and the Washington State Nurses Association. The joint statement was adopted by the board of trustees of each organization after many months of work by the executive committees of both organizations. The goals are as follows:

> "To enhance good communication between the attending physician, the nurse in charge, the resident physician, and other involved personnel in instances where the use of cardio-pulmonary resuscitation may not be indicated in part, or in whole, or when a patient requests CPR not be performed, the following joint statement is presented:
>
> "The decision of no code is best made with informed consent, following discussion, whenever possible, with the patient and

family, and when appropriate with the consulting physicians, nurses, clergy, and attorney.

"There must be clear cut communication between the physician and the nurse since failure to communicate interferes with good patient care and places both parties at risk. No code status must be written on an order sheet like any other order and signed by the attending physician.

"This decision should not be allowed to influence adversely the quality of care the patient subsequently receives, rather it should lead to continued emphasis on care, compassion, and relief of suffering."

2.18 UNNECESSARY SERVICES. It is unethical for a physician to provide or prescribe unnecessary services or unnecessary ancillary facilities. (II, VII)

2.19 WORTHLESS SERVICES. A physician should not seek compensation for providing services which he knows or should know are generally regarded among reputable physicians as worthless. (II, VII)

3.00 OPINIONS ON INTERPROFESSIONAL RELATIONS

3.01 NONSCIENTIFIC PRACTITIONERS. It is wrong to engage in or to aid and abet in treatment which has no scientific basis and is dangerous, is calculated to deceive the patient by giving him false hope, or which may cause the patient to delay in seeking proper care until his condition becomes irreversible.

Physicians should also be mindful of state laws which prohibit a physician from aiding and abetting an unlicensed person in the practice of medicine, aiding or abetting a person with a limited license in providing services beyond the scope of his license, or undertaking the joint medical treatment of patients under the foregoing circumstances.

A physician is otherwise free to accept or decline to serve anyone who seeks his services, regardless of who has recommended that the individual see the physician. (III, VI)

3.02 NURSES. The primary bond between medical practice and nursing is mutual ethical concern for patients. One of the duties in providing reasonable care is fulfilled by a nurse who carries out the orders of the attending physician. Where orders appear to the nurse to be in error or contrary to customary medical and nursing practice, the physician has an ethical obligation to explain those orders to the nurse involved. Whenever a nurse recognizes or suspects error or discrepancy in a physician's orders, the nurse has an obligation to call this to the attention of the physician. The ethical physician should neither expect nor insist that nurses follow orders contrary to standards of good medical and nursing practice. In emergencies when prompt action is necessary and the physician is not immediately available, in the performance of reasonable care a nurse may be justified in acting contrary to the physician's standing orders for the safety of the patient. Such occurrences should not be considered to be a breakdown in professional relations. (IV, V)

3.03 OPTOMETRY. An ophthalmologist may employ an optometrist as ancillary personnel to assist him provided the optometrist is identified to patients as an optometrist.

A physician may send his patient to a qualified and ethical optometrist for optometric services. The physician would be ethically remiss, of course, if before doing so he did not ensure that there was an absence of any medical reason for his patient's complaint, and he would be equally remiss if he sent a patient without having made a medical evaluation of the patient's condition.

Physicians may teach in recognized schools of optometry for the purpose of improving the quality of optometric education. The scope of this teaching may embrace subjects within the legitimate scope of optometry which are designed to prepare students to engage in optometry within the limits prescribed by law. (V, VI)

3.04 REFERRAL OF PATIENTS. A physician may refer a patient for diagnostic or therapeutic services to another physician, limited practitioner, or any other provider of health care services permitted by law to furnish such services, whenever he believes that this may benefit the patient. As in the case of referrals to physician-specialists, referrals to limited practitioners should be based on their individual competence and ability to perform the services needed by the patient. A physician should not so refer a patient unless he is confident that the services provided on referral will be performed competently and in accordance with accepted scientific standards and legal requirements. (V, VI)

3.05 SPECIALISTS. A physician may choose to limit his practice to a specialty or to a certain specialized service. He may also choose to provide services as a consultant to other physicians, or to patients sent to him by other physicians, or to patients at a hospital with which he has a contractual arrangement. He may choose to accept or decline patients sent to him by licensed limited practitioners or by laymen.

A physician may choose those persons whom he will accept as patients and also may exercise his choice by the terms of contractual arrangement with other physicians, medical groups, hospitals or other institutions. A physician may freely choose those whom he will serve, in the absence of legal considerations to the contrary.

The specialist or other physician in charge of the case should keep the patient or his lawful representative informed about the diagnosis and treatment of the patient's ailment. Where the specialist provides diagnostic services to a patient recommended to him by a licensed limited practitioner or by a layman, and the results indicate the possible need for surgical or drug treatment, the specialist has a professional responsibility to so inform the patient. A physician-patient relationship exists under these circumstances between the specialist and the person receiving diagnostic services. Although a physician may choose to limit his practice to certain diagnostic services, he is still subject to the provision in Section 5 of the Principles of Medical Ethics that he may not neglect a patient under his care. He should always get a written report.

3.06 SPORTS MEDICINE. The rules and conditions governing amateur and professional contact sports such as football and hockey, and the extent to which the risks of bodily injury shall be acceptable to society, require informed decision-making in which the medical profession has an essential role.

The professional responsibility of the physician who serves in a medical capacity at an athletic contest or sporting event is to protect the health and safety of the contestants. The desire of spectators, promoters of the event or even the injured athlete that he should not be removed from the contest should not be controlling. The physician's judgment should be governed only by medical considerations. (I, VII)

3.07 TEACHING. Physicians are free to engage in any teaching permitted by law for which they are qualified.

4.00 OPINIONS ON HOSPITAL RELATIONS

4.01 ADMISSION FEE. Charging a separate and distinct fee for the incidental, administrative, non-medical service the physician performs in securing the admission of a patient to a hospital is not in keeping with the traditions of the American Medical Association and is unethical. (IV)

4.02 ASSESSMENTS, COMPULSORY. The hospital management does not have the privilege to make compulsory assessments of members of the medical staff for building funds or to demand an audit of staff members' personal financial records as a requisite for staff appointment.

Compulsory assessments, that is, assessments which if not paid would automatically cause the physicians to lose staff membership, are not in the best traditions of ethical practice. It is not proper to condition medical staff membership on compulsory assessments for any purpose. However, the medical staff may assess dues to its members as an appropriate and ethical means by which the organized staff can generate revenue which can be utilized to further the interests of the members (also see 4.06). (VI)

4.03 BILLING FOR HOUSESTAFF SERVICES. When a physician assumes responsibility for the services rendered to a patient by a physician housestaff, the physician may ethically bill the patient for services which were performed under the physician's personal observation, direction, and supervision. (II)

4.04 HEALTH FACILITY OWNERSHIP BY PHYSICIAN. A physician may own or have a financial interest in a for-profit health facility, nursing home, or other health facility, such as free-standing surgical center or emergency clinic. However, the physician has an affirmative ethical obligation to disclose his ownership of a health facility to his patient, prior to admission or utilization.

Under no circumstances may the physician place his own financial interest above the welfare of his patients. The prime objective of the medical profession is to render service to humanity; reward or financial gain is a subordinate consideration. For a physician to unnecessarily hospitalize a patient or prolong a patient's stay in the health facility for the physician's financial benefit would be unethical.

If a conflict develops between the physician's financial interest and the physician's responsibilities to the patient, the conflict must be resolved to the patient's benefit. (II)

When a question arises regarding the proper and ethical use that a physician makes of his ownership or interest in a for-profit health facility, the local medical society has the obligation to ascertain the facts and, based on an analysis of those facts, provide guidance to its own members.

4.05 ORGANIZED MEDICAL STAFF. The organized medical staff is an integral part of the hospital structure. Under authority delegated by the governing board, it performs essential hospital functions. The organized medical staff conducts professional activities that are designed to improve professional skills and to enhance the quality of patient care in the hospital.

The organized medical staff performs essential hospital functions even though it may often consist primarily of independent practicing physicians who are not hospital employees. As a practical matter, however, the organized medical staff may enjoy a dual status. In addition to functioning as a division of the hospital, members of the organized medical staff may choose to act as a group for the purpose of communicating and dealing with the governing board and others with respect to matters that concern the interest of the organized medical staff and its members. This is ethical so long as there is no adverse interference with patient care or violation of applicable laws. Peer review is ethical and proper as long as it is done without malice. Appropriate procedures for appeal must be available and outlined in the medical staff bylaws. (IV, VI)

In addition to functioning as a division of the hospital, members of the organized medical staff may choose to act as a group for the purpose of communicating and dealing with the governing board and others with respect to matters that concern the interest of the organized medical staff and its members. To function and to properly represent its members, the organized medical staff needs a source of income independent from the hospital. Dues are an appropriate and ethical means whereby the organized staff can generate revenue which can be utilized to further the interests of the members.

4.06 PHYSICIAN-HOSPITAL CONTRACTUAL RELATIONS. There are various financial or contractual arrangements that physicians and hospitals may enter into and find mutually satisfactory. A physician may, for example, be a hospital employee, a hospital-associated medical specialist, or an independent practitioner with staff privileges. The form of the contractual or financial arrangement between physicians and hospitals depends on the facts and circumstances of each situation.

A physician may be employed by a hospital for a fixed annual amount, for a certain amount per hour, or pursuant to other similar arrangements that are related to the professional services, skill, education, expertise, or time involved.

Any conduct that results in the provision of unnecessary services or over utilization of services or facilities, is, of course, unethical and should be discouraged. If such problems arise, though, these problems should be addressed directly and considered in the light of the facts and circumstances of the particular situation. (VI)

4.07 STAFF PRIVILEGES. The mutual objective of both the governing board and the medical staff is to improve the quality and efficiency of patient care in the hospital. Decisions regarding hospital privileges should be based upon the training, experience, and demonstrated competence of candidates, taking into consideration the availability of facilities and the overall medical needs of the community, the hospital, and especially patients. Personal friendships, antagonisms, jurisdictional disputes, or fear of competition should be disregarded in making these decisions. Physicians who are involved in the granting, denying, or termination of hospital privileges have an ethical responsibility to be guided primarily by concern for the welfare and best interests of patients in discharging this responsibility. Obtaining medical staff privileges is a privilege and not necessarily a right. The granting of medical staff privileges should be based on one's knowledge, training, and other relevant factors. Good medical practice has a higher priority than matters of hospital economy. (IV, VI, VII)

5.00 CONFIDENTIALITY, ADVERTISING, COMMUNICATIONS, MEDIA RELATIONS

5.01 ADVERTISING AND PUBLICITY. There are no restrictions on advertising by physicians except those that can be specifically justified to protect the public from deceptive practices. A physician may publicize himself as a physician through any commercial publicity or other form of public communication (including any newspaper, magazine, telephone directory, radio, television, or other advertising) provided that the communication shall not be misleading because of the omission of necessary material information, shall not contain any false or misleading statement, or shall not otherwise operate to deceive.

The form of communication should be designed to communicate the information contained therein to the public in a direct, dignified, and readily comprehensible manner. Aggressive, high-pressure advertising and publicity may create unjustified medical expectations. Any advertisement or publicity, regardless of format or content, should be true and not misleading.

The communication may include: a) the educational background of the physician; b) the basis on which fees are determined (including charges for specific services); c) available credit or other methods of payment; and d) other information about the physician which a reasonable person might regard as relevant in determining whether to seek the physician's services. Any advertising or other public representation where the physician claims to be board certified shall name the certifying board.

Patient testimonials, like other methods of advertising, are permitted to the extent they are not false or misleading. However, a physician using a testimonial must be able to substantiate that the experience related in the testimonial is representative of what the patients generally experience. Statements relating to the quality of medical services are extremely difficult, if not impossible, to verify or measure by objective standards. Claims regarding experience, competence, and the quality of the physician's services may be made if they can be factually supported and if they do not imply that he has an exclusive and unique skill or remedy. A statement that a physician has cured or successfully treated a large number of cases involving a particular serious aliment may imply a certainty of result and create unjustified and misleading expectations in prospective patients.

Consistent with federal regulatory standards which apply to commercial advertising, a physician who is considering the placement of an advertisement or publicity release, whether in print, radio, or television, should determine in advance that his communication or message is explicitly and implicitly truthful and not misleading. These standards require the advertiser to have a reasonable basis for claims before they are used in advertising. The reasonable basis must be established by those facts known to the advertiser, and those which a reasonable, prudent advertiser should have discovered.

As used herein, references to a "physician" apply also to information relating to the physician's group, partners, or associates. Any communication or message within the scope of this opinion should include the name of at least one physician responsible for its content.

Nothing in any opinion of the Judicial Council is intended or shall be construed to discourage or to limit advertising and representations which are not false or deceptive within the meaning of Section 5 of the Federal Trade Commission Act.

Competition – some competitive practices accepted in ordinary commercial and industrial enterprise – where profit-making is the primary objective – are inappropriate among physicians. Commercial enterprises, for example, are free to solicit business by paying commissions. They have no duty to lower prices to the

poor. Commercial enterprises are generally free to engage in advertising "puffery", to be boldly self-laudatory in making claims of superiority, and to emphasize favorable features without disclosing unfavorable information.

Physicians, by contrast, have an ethical duty to subordinate financial reward to social responsibility. A physician should not engage in practices for pecuniary gain that interfere with his medical judgment and skill or cause a deterioration of the quality of medical care. Ability to pay should be considered in reducing fees, and excessive fees are unethical.

Physicians should not pay or receive commissions or rebates or give kickbacks for the referral of patients to other health care providers. Likewise, they should not make extravagant claims or proclaim extraordinary skills. Such practices, however common they may be in the commercial world, are unethical in the practice of medicine because they are injurious to the public.

Freedom of choice of physician and free competition among physicians are prerequisites of optimal medical care. The Principles of Medical Ethics are intended to curtail abusive practices that impinge on these freedoms and exploit patients and the public. (II)

5.02 ADVERTISING AND HMOs. A physician may provide medical services to members of a prepaid medical care plan or to members of a health maintenance organization which seeks members or subscribers through advertising. Physicians practicing in prepaid plans or HMOs are subject to the same ethical principles as are other physicians. Advertising which would lead prospective members or subscribers to believe that the services of a named physician who has a reputation for outstanding skill would be routinely available to all members or subscribers, if in fact this is not so, is deceptive. However, the publication by name of the roster of physicians who provide services to members, the type of practice in which each is engaged, biographical and other relevant information is not a deceptive practice. (II, VI)

5.03 COMMUNICATIONS MEDIA: PRESS RELATIONS. A physician should not discuss a patient's medical condition, disease, or illness with the press without the patient's authorization. The patient or the patient's lawful representative may authorize a physician to disclose health information concerning the patient to the press. The physician may release only authorized information or that which is public knowledge. (IV)

5.04 COMMUNICATIONS MEDIA: STANDARDS OF PROFESSIONAL RESPONSIBILITY. Because certain news is a part of the public record or is a matter of concern to civil authorities, it is readily available for publication. Physicians should cooperate with the press to insure that medical news of this sort is available more promptly and more accurately than would be possible without their assistance. News in this category, known as news in the public domain, includes: births, deaths, accidents, and police cases.

The following information in the public domain can be made available without the patient's consent:

A. Personal information: patient's name, address, age, sex, race, marital status, employer, occupation, name of parents in case of births, name of next-of-kin in case of deaths.

B. Nature of accident: only general information regarding injuries will be released. This consists of the name of the injured portion of the body, such as back injury and the like. It may be stated that there are internal injuries.

If the patient is unconscious when brought to the hospital, a statement to that effect may be made.

Statements regarding the circumstances surrounding shootings, knifings, and poisonings are properly police matters, and questions whether they were accidental or otherwise should be referred to the appropriate authorities.

A statement may be made to the effect that the patient was injured by a knife or other sharp instrument, but no statement may be made as to whether or not it was assault, accident, or self-inflicted.

No statement may be made that there was a suicide or attempted suicide.

No statement may be made to the effect that intoxication or drug addiction was involved.

C. Diagnosis and prognosis: inasmuch as a diagnosis may be made only by a physician and may depend upon x-ray and laboratory studies, no statement regarding diagnosis should be made except by or on behalf of the attending physician. For the same reason, prognosis will be given only by the attending physician or at his direction.

D. Patient's condition: a statement may be made as to the general condition of the patient using the following classifications: minor injuries or similar general diagnosis, good, fair, serious, critical.

When information concerning a specific patient is requested, the physician must obtain the consent of the patient or his authorized representative before releasing such information. The patient's decision is final under the law. Physicians are ethically and legally required to protect the personal privacy and other legal rights of patients. The physician-patient relationship and its confidential nature must be maintained. With these considerations in mind, the physician may assist the representatives of the media in every way possible.

E. The executive offices of the Washington State Medical Association are available to representatives of the news media to provide prompt responses to health and medically related inquiries. If the information sought is not readily available, the executive offices will attempt to obtain the information promptly or assist the inquirer in finding another source.

Members of the Executive Committee of the Washington State Medical Association, or their spokesperson, may be quoted by name in matters of public interest. County medical societies are urged to adopt a similar policy with regard to designated spokespersons. A list of these spokespersons is available to the news media. In responding to queries or issuing statements which are in the public interest, these spokespersons are not to be considered to be seeking personal publicity.

Speakers at medical meetings and local physicians connected with such meetings sponsored by WSMA or other medical organizations will be accessible to the news media without prior approval of the Association.

Responsibility for arranging news coverage rests with the sponsoring group. It is understood that notifying the news media of an event carries an indication that coverage of the presentations will be welcomed.

On granting interviews to representatives of the general press, physicians should be aware that they probably will not be permitted to edit the material before publication.

Physicians are not authorized to participate in public controversial discussions as spokesperson for the WSMA without prior approval by the Association. However, any physician has the right to express opinions as an individual.

Doctors of medicine are expected to refrain from sponsoring, directly or by implication, any non-prescription products.

Because certain news is a part of the public record or is a matter of concern to civil authorities, it is readily available for publication. Physicians should cooperate with the press to insure that medical news of this sort is available more promptly and more accurately than would be possible without their assistance.

F. For the purpose of clarity, the following principles should guide physicians who appear on TV or radio programs or who are interviewed in other media of public information, such as newspapers and magazines:

a) When introduced as a physician on TV or radio programs or quoted in an article as a physician in newspapers and magazines, such individuals cannot escape the implication of representing the medical profession and his conduct should be in keeping with the high standards of the profession.

b) Sound judgment and good common sense are expected of any physician when appearing on TV or radio programs or in other media of public information, such as newspapers or magazines, in whatsoever capacity.

G. The Judicial Council construes the Principles of Medical Ethics as encouraging physicians to work with the communications media as an integral and important part of the principle of upholding the responsibility of the physician to society as a whole.

H. Physicians are ethically and legally required to protect the personal privacy and other legal rights of patients. The physician-patient relationship and its confidential nature must be maintained. With these considerations in mind, the physician may assist the representatives of these media in every way possible. (IV)

5.05 CONFIDENTIAL CARE FOR MINORS.

A. When minor patients request confidential services, physicians should encourage them to involve their parents. This includes making efforts to obtain the minor's reasons for not involving their parents and correcting misconceptions that may be motivating their objections. The determination

of the minor's need for confidentiality must consider the risk of parental abuse and be consistent with facilitating the timely utilization of needed health care.

B. Physicians who treat minor patients have an ethical duty to promote the autonomy of such patients by involving them in the medical decision-making process to a degree commensurate with their maturity, experience and judgment.

C. Where the law does not require otherwise:

1. Physicians should permit competent minor patients to consent to medical care and should not notify parents without the patients' consent. Depending on the seriousness of the decision, competence may be evaluated by physicians for most minors. When necessary, experts in adolescent medicine or child psychological development should be consulted. Use of the courts for competence determinations should be made only as a last resort.

2. When a minor patient requests contraceptive services, pregnancy-related care (including pregnancy testing, prenatal and postnatal care, and delivery services), or treatment for sexually transmitted disease, drug and alcohol abuse or mental illness, physicians must recognize that requiring parental involvement may be counterproductive to the health of the patient. Physicians should encourage parental involvement in these situations. However, if the minor continues to object, his or her wishes ordinarily should be respected. If the physician is uncomfortable with providing services without parental involvement, and alternative confidential services are available, the minor should be referred to those services. In cases when the physician believes that without parental involvement and guidance, the minor will face a serious health threat, and there is reason to believe that the parents will be helpful and understanding, disclosing the problem to the parents is ethically justified. When the physician does breach confidentiality to the parents, he or she must discuss the reasons for the breach with the minor prior to the disclosure.

3. For minor patients who are mature enough to be unaccompanied by their parents for their examinations, confidentiality of information disclosed during an exam, interview, or in counseling should be maintained. Such information may be disclosed to parents when the patient consents to disclosure. Confidentiality may be justifiably

breached in situations for which confidentiality for adults may be breached. In addition, confidentiality for immature minors may be ethically breached, after discussing reasons for the breach with the minor, when necessary to enable the parent to make a mature and informed decision about treatment for the minor or when such a breach is necessary to avert serious harm to the minor.

4. Physicians should not feel, or be, compelled to require minors to obtain consent of their parents before deciding whether to undergo an abortion. The patient ÄÄ even an adolescent ÄÄ generally must decide whether, on balance, parental involvement is advisable. Accordingly, minors should ultimately be allowed to decide whether parental involvement is appropriate. Physicians should explain under what circumstances (e.g., life-threatening emergency) the minor's confidentiality will need to be abrogated.

5. Physicians should ensure that minor patients have made an informed decision after giving careful consideration to the issues involved. They should encourage their minor patients to consult alternative sources if parents are not going to be involved in the abortion decision. Minors should be helped to seek the advice and counsel of those adults in whom they have confidence, including professional counselors, relatives, friends, teachers or the clergy.

D. When laws violate these ethical standards, physicians should fulfill their legal requirements. However, such laws should be altered to conform with these guidelines. Physicians should play an active role in changing laws that are not in conformity with these standards.

E. Physicians should consider the possibility of inadvertent breach of confidentiality when a minor is receiving care under their parent's insurance, resulting in specific billing statements to the parents.

5.06 CONFIDENTIALITY. The information disclosed to a physician during the course of the relationship between physician and patient is confidential to the greatest possible degree. The patient should feel free to make a full disclosure of information to the physician in order that the physician may most effectively provide needed services. The patient should be able to make this disclosure with the knowledge that the physician will respect the confidential nature of the communication. The physician should not reveal confidential communications or information without the express consent of the patient, unless required to do so by law.

The obligation to safeguard patient confidences is subject to certain exceptions which are ethically and legally justified because of overriding social considerations. Where a patient threatens to inflict serious bodily harm to another person and there is a reasonable probability that the patient may carry out the threat, the physician should take reasonable precautions for the protection of the intended victim, including notification of law enforcement authorities. Also, communicable diseases and gunshot and knife wounds should be reported as required by applicable statutes or ordinances. (IV)

5.07 CONFIDENTIALITY: ATTORNEY-PHYSICIAN RELATION. The patient's history, diagnosis, treatment, and prognosis may be discussed with the patient's lawyer with consent of the patient or his lawful representative. The physician has obligations to society as a whole in addition to his obligations to his patient as an individual. In many instances, the peculiar knowledge and attainments of the physician are indispensable to patients or others in the administration of business and government and in the usual conduct of certain daily affairs. When this knowledge, acquired during the course of the physician-patient relationship, is necessary to enable the patient to obtain his just due, the physician should make it available for the patient's benefit under proper conditions. Discussion with or report to the patient's attorney may be proper and necessary in order for the patient to perfect a claim. The attending physician may ethically discuss such matters with the attorney providing that the patient has consented to the discussion.

It is not improper for a physician to testify in court or before a workman's compensation board or the like in any personal injury or related case. (IV)

5.08 CONFIDENTIALITY: COMPUTERS. The utmost effort and care must be taken to protect the confidentiality of all medical records. This ethical principle applies to computerized medical records as it applies to any other medical records. (IV)

5.09 CONFIDENTIALITY: DRUG DISPENSING AND VENEREAL DISEASE. Although not generally encouraged, there are circumstances in which physicians may dispense drugs. The obligation of the physician to protect the patient's confidences is one of the most serious obligations imposed on him. Accordingly, the physician is not precluded from dispensing appropriate medication, such as ampicillinprobenecid, to his patient who has been diagnosed as having a venereal disease, such as gonorrhea, since forcing a patient to have such a drug "dispensed in the presence of the pharmacist" could very well destroy the confidential nature of that particular physician-patient relationship.

5.10 CONFIDENTIALITY: INSURANCE COMPANY REPRESENTATIVE. History, diagnosis, prognosis, and the like acquired during the physician-patient relationship may be disclosed to an insurance company representative only if the patient or his lawful representative has consented to the disclosure. A physician's responsibilities to his patient are not limited to the actual practice of medicine. They also include the performance of some services ancillary to the practice of medicine. These services might include certification that the patient was under the physician's care and comment on the diagnosis and therapy in the particular case.

5.11 CONFIDENTIALITY: PHYSICIANS IN INDUSTRY. Where a physician's services are limited to pre-employment physical examinations or examinations to determine if an employee who has been ill or injured is able to return to work, no physician-patient relationship exists between the physician and those individuals. Nevertheless, the information obtained by the physician as a result of such examinations is confidential and should not be communicated to a third party without the individual's prior written consent, unless it is required by law. If the individual authorizes the release of medical information to an employer or a potential employer, the physician should release only that information which is reasonably relevant to the employer's decision regarding that individual's ability to perform the work required by the job.

A physician-patient relationship does exist when a physician renders treatment to an employee, even though the physician is paid by the employer. If the employee's illness or injury is work-related, the release of medical information as to the treatment provided to the employee may be subject to the provisions of worker's compensation laws. The physician must comply with the requirements of such laws, if applicable. However, the physician may not otherwise discuss the employee's health condition with the employer without the employee's consent or, in the event of the employee's incapacity, the family's consent.

Whenever statistical information about employees' health is released, all employee identities should be deleted. (IV)

5.12 SPECIALTY DESIGNATIONS IN DIRECTORIES. The current AMA list of medical designations is the WSMA-approved list of medical specialties. The WSMA-approved list may be adopted by county medical societies as a guide to how their members should list themselves in various directories. The individual county societies retain the right to add further designations to meet local needs. The individual society shall be responsible for supervising its own members in this

matter. The WSMA Judicial Council will function as the appellate body in case of disciplinary action by the county medical society resulting from an unresolved dispute over directory listings. (II)

6.00 OPINIONS ON FEES AND CHARGES

6.01 COLLECTION AGENCIES. In referring a delinquent account to a collection agency, the physician should first give due consideration to the patient's ability to pay the fee which is due. The physician should not utilize the services of a collection agency whose tactics and methods of collection might be unfair or abusive; nor should he enter into any arrangement under which he would lose complete control of the delinquent account or the method of its collection.

6.02 COMPETITION. Competition between and among physicians and other health care practitioners on the basis of competitive factors such as quality of services, skill, experience, miscellaneous conveniences offered to patients, credit terms, fees charged, etc. is not only ethical but is encouraged. Ethical medical practice thrives best under free market conditions when prospective patients have adequate information and opportunity to choose freely between and among competing physicians and alternate systems of medical care. (VII)

6.03 FEES FOR MEDICAL SERVICES. A physician should not charge or collect an illegal or excessive fee. For example, an illegal fee occurs when a physician accepts an assignment as full payment for services rendered to a Medicare patient and then bills the patient for an additional amount. A fee is excessive when after a review of the facts a person knowledgeable as to current charges made by physicians would be left with a definite and firm conviction that the fee is in excess of a reasonable fee. Factors to be considered as guides in determining the reasonableness of a fee include the following:

a) The difficulty and/or uniqueness of the services performed and the time, skill, and experience required;

b) The fee customarily charged in the locality for similar physician services;

c) The amount of the charges involved;

d) The quality of performance;

e) The nature and length of the professional relationship with the patient; and

f) The experience, reputation, and ability of the physician in performing the kind of services involved. (II)

6.04 FEES: GROUP PRACTICE. The division of income among members of a group, practicing jointly or in a partnership, may be determined by the members of the group and may be based on the value of the professional medical services performed by the member and his other services and contributions to the group. (II)

6.05 FEE SPLITTING. By the term "secret splitting of fees" is meant the sharing by two or more men in a fee which has been given by the patient supposedly as the reimbursement for the service of one man alone. By "secrecy" is meant that the division of the fee is done without the knowledge of the patient or some representative of the family. It includes those cases in which the term "assistant" is used as a subterfuge to obtain a part of the fee which otherwise could not be rightfully claimed. It includes the giving or receiving of a commission, which constitutes fee splitting and is unethical.

It is ethically permissible in certain circumstances, however, for a surgeon to engage other physicians to assist him in the performance of a surgical procedure and to pay a reasonable amount for such assistance, provided the nature of the financial arrangement is made known to the patient. This principle applies whether or not the assisting physician is the referring doctor.

A physician may only receive from his patient payment for rendered medical services. Hence, it should be apparent that no rebate of any kind, in any form or from any source, can be accepted. This applies also to rebates coming from agents or owners of optical companies. They are, in every case, absolutely unethical.

A physician may not accept a gift of substance from a manufacturer or a distributor of drugs, remedies, appliances, or services for prescribing these products for his patients. This amounts to rebating. It is ethically improper because it could influence the physician to prescribe the donor's product. If a product or service is prescribed for its effectiveness, it would be preferable that it be discounted so that the patient, rather than the physician, benefits.

In many cases insurance companies insist on a joint or combined bill, but the bill is being paid in most instances by two checks. This is not considered unethical, and

all insurance plans which do not pay the individual physician in this manner should be urged to do so.

When two or more physicians actually and in person render services to one patient, they should render separate bills. There are cases, however, in which the patient may make a specific request to one of the physicians attending him that one bill be rendered for the entire services. Should this occur, it is considered to be ethical if the physician from whom the bill is requested renders an itemized bill setting forth the services rendered by each physician and the fees charged. The amount of the fees charged should be paid directly to the individual physicians who rendered the services in question. (II)

6.06 FEE SPLITTING: CLINIC OR LABORATORY REFERRALS. Clinics or laboratories that compensate physicians based on the amount of work referred by the physician to the clinic or laboratory are engaged in fee splitting which is unethical. (II)

6.07 FEE SPLITTING: DRUG PRESCRIPTION REBATES. A physician may not accept any kind of payment or compensation from a drug company for prescribing its products. The physician should keep the following considerations in mind:

1) A physician should only prescribe a drug based on his reasonable expectations of the effectiveness of the drug for the particular patient.

2) The quantity of the drug prescribed should be no greater than that which is reasonably required for the patient's condition. (II)

6.08 FEE SPLITTING: PURCHASE OF MEDICAL PRACTICE ON A PERCENTAGE BASIS. The purchase of a medical practice on a percentage basis is contrary to and in violation of the Principles. A physician may pay anything he wants to for the practice as long as a set price is established, but it is unethical for a physician to pay a percentage of the income of the practice that he has purchased as payment for it. The use of a percentage of fees or an indefinite sum as the purchase price for a medical practice results in dividing fees paid for professional service with a third party -- a stranger to the physician-patient relationship. Once a price has been established, it may be paid according to the mutual agreement of the parties. Payment of such an established price predicated on a percentage of the income of the purchaser is not contrary to the Principles. It is axiomatic that a physician must bill a patient for professional services that he renders to the patient. He must not divide that fee with another. Such practice violates the physician-

patient relationship and may be regarded as a commission for having referred the patient. (II)

6.09 FEE SPLITTING AND HOSPITALS. The suggestion has been made by some hospitals that physicians who utilize the hospital facilities should pay to the hospital a percentage of the fees which they receive from their patients while being cared for in the hospital.

The suggested proposal is clearly a case of splitting or sharing professional fees with a lay organization which has already levied its regular bill for the services which it legitimately rendered, and therefore is improper. (II)

6.10 FEE SPLITTING: RENTALS. An arrangement by virtue of which a physician leases office space for a percentage of gross income is not acceptable; it is violative of ethical principles. The practice indirectly results in fee splitting and tends to exploit the practice of medicine.

If the size of a physician's practice increases and imposes additional demands on the facilities of the building, these facts may be considered when the time comes to re-negotiate the rental value of the leased premises, and a new fixed rental, taking these items into account, might be agreed upon. (II)

6.11 INSURANCE FORM COMPLETION CHARGE. The attending physician should complete without charge the appropriate "simplified" insurance claim forms as a part of his service to the patient to enable the patient to receive his benefits. A charge for more complex forms may be made in conformity with local custom. (II)

6.12 INTEREST CHARGES AND FINANCE CHARGES. Although harsh or commercial collection practices are discouraged in the practice of medicine, a physician who has experienced problems with delinquent accounts may properly choose to request that payment be made at the time of treatment or add interest or other reasonable charges to delinquent accounts. The patient must be notified in advance of the interest or other reasonable finance or service charges by such means as the posting of a notice in the physician's waiting room, the distribution of leaflets describing the office billing practices, and appropriate notations on the billing statement. The physician must comply with state and federal laws and regulations applicable to the imposition of such charges. The Judicial Council encourages physicians who choose to add an interest or finance charge to accounts not paid within a reasonable time to make exceptions in hardship cases. (II)

6.13 LABORATORY BILL. When it is not possible for the laboratory bill to be sent directly to the patient, the referring physician's bill to the patient should indicate the actual charges for laboratory services, including the name of the laboratory, as well as any separate charges for his own professional services. (II)

6.14 PROFESSIONAL COURTESY. The following guidelines are offered as suggestions to aid physicians in resolving questions related to professional courtesy:

1) Where professional courtesy is offered by a physician but the recipient of services insists upon payment, the physician need not be embarrassed to accept a fee for his services.

2) Professional courtesy is a tradition that applies solely to the relationship that exists among physicians. If a physician or his dependents have insurance providing benefits for medical or surgical care, a physician who renders such service may accept the insurance benefits without violating the traditional practice of physicians caring for the medical needs of colleagues and their dependents without charge.

3) In the situation where a physician is called upon to render services to another physician or his dependents with such frequency as to involve a significant proportion of his professional time, or in cases of long-term extended treatment, fees may be charged on an adjusted basis so as not to impose an unreasonable burden upon the physician rendering services.

4) Professional courtesy should always be extended without qualification to the physician in financial hardship and his dependents.

6.15 SURGICAL ASSISTANT'S FEE. Each physician engaged in the care of the patient is entitled to compensation commensurate with the value of the services he has personally rendered.

No physician should bill or be paid for a service which he does not perform; mere referral does not constitute a professional service for which a professional charge should be made or for which a fee may be ethically paid or received.

When services are provided by more than one physician, each physician should submit his own bill to the patient and be compensated separately, if possible.

It is ethically permissible in certain circumstances, however, for a surgeon to engage other physicians to assist him in the performance of a surgical procedure and to pay a reasonable amount for such assistance, provided the nature of the financial arrangement is made known to the patient. This principle applies whether or not the assisting physician is the referring physician. (II)

7.00 OPINIONS ON PHYSICIAN RECORDS

7.01 RECORDS OF PHYSICIANS: AVAILABILITY OF INFORMATION TO OTHER PHYSICIANS.

The interest of the patient is paramount in the practice of medicine, and everything that can reasonably and lawfully be done to serve that interest must be done by all physicians who have served or are serving the patient. A physician who formerly treated a patient should not refuse for any reason to make his records of that patient promptly available on request to another physician presently treating the patient. Proper authorization for the use of records must be granted by the patient. Medical reports should not be withheld because of an unpaid bill for medical services. (IV)

7.02 RECORDS OF PHYSICIANS: INFORMATION AND PATIENTS.

Notes made in treating a patient are primarily for the physician's own use and constitute his personal property. However, on request of the patient, a physician should provide a copy of a summary of the record to the patient or to another physician, an attorney, or other person designated by the patient.

Several states have enacted statutes that authorize patient access to medical records. These statutes vary in scope and mechanism for permitting patients to review or copy medical records. Access to mental health records, particularly, may be limited by statute or regulation. A physician should become familiar with the applicable laws, rules, or regulations on patient access to medical records.

The record is a confidential document involving the physician-patient relationship and should not be communicated to a third party without the patient's prior written consent, unless required by law or to protect the welfare of the individual or the community. Medical reports should not be withheld because of an unpaid bill for medical services. Simplified routine insurance reimbursement forms should be prepared without charge, but a charge for complex, complicated, or multiple reports may be made in conformity with local custom. (IV)

7.03 RECORDS OF PHYSICIANS ON RETIREMENT.

A patient's records may be necessary to the patient in the future not only for medical care but also for

employment, insurance, litigation, or other reason. When a physician retires or dies, patients should be notified and urged to find a new physician and should be informed that upon authorization records will be sent to the new physician. Records which may be of value to a patient and which are not forwarded to a new physician should be retained, either by the physician himself, another physician, or such other person lawfully permitted to act as custodian of the records. (IV)

7.04 RECORDS ON TERMINATION OF PARTNERSHIP. When two or more physicians, who are partners in the practice of medicine, terminate the partnership relationship, any question regarding possession of patients' clinical records should be determined on the basis of what is best for each patient.

When a physician-employee terminates his relationship with an individual physician, a group of physicians, or a clinic, any question regarding possession of patients' clinical records should be determined on the basis of what is best for each patient, consistent with any contractual arrangements that may have been made. Should the physician-employee have need to review these records in the best interest of a patient under his care, their contents should be available to him, with the consent of the patient.

In case of disagreement, the proper committee of the local medical society may be able to assist in resolving the problem. (IV)

7.05 SALE OF A MEDICAL PRACTICE. A physician or the estate of a deceased physician may sell to another physician the elements which comprise his practice, such as furniture, fixtures, equipment, office leasehold, and goodwill. In the sale of a medical practice, the purchaser is buying not only the furniture and fixtures, but also goodwill, i.e., the opportunity to take over the patients of the seller.

The transfer of records of patients is subject, however, to the following:

1. All active patients should be notified that the physician (or his estate) is transferring the practice to another physician who will retain custody of their records and that at their written request, within a reasonable time as specified in the notice, the records or copies will be sent to any other physician of their choice. Rather than destroy the records of a deceased physician it is better that they be transferred to a practicing physician who will retain them subject to requests from patients that they be sent to another physician.

2. A reasonable charge may be made for the cost of duplicating records.

3. A physician or his estate who is selling his practice may not ethically sell his patients' records to another physician. (IV)

8.00 OPINIONS ON PRACTICE MATTERS

8.01 APPOINTMENT CHARGES. A physician may charge a patient for a missed appointment or for one not canceled within 24 hours in advance if the patient is fully advised that the physician will make such a charge. The practice, however, should be resorted to infrequently and always with the utmost consideration for the patient and his circumstances. (VI)

8.02 CLINICS. Physicians practicing in a group or clinic are, both individually and as a group, subject to the Principles of Medical Ethics. (VI)

8.03 CONFLICT OF INTEREST - PHYSICIAN SELF-REFERRAL.

A. Physician investment in health-care facilities can provide important benefits for patient care. However, when physicians refer patients to facilities in which they have an ownership interest, a potential conflict of interest exists. In general, physicians should not refer patients to a health care facility outside their office practice at which they do not directly provide care or services when they have an investment interest in the facility.

B. Physicians may invest in and refer to an outside facility, whether or not they provide direct care or services at the facility, if there is a demonstrated community need for the facility and alternative financing is not available. There may be situations in which a needed facility would not be built if referring physicians were prohibited from investing in the facility. Need might exist when there is no facility of reasonable quality in the community or when use of existing facilities is onerous for patients. In such cases, the following requirements should also be met:

1. Individuals who are not in the position to refer patients to the facility must be given a bona fide opportunity to invest in the facility, and they must be able to invest on the same terms that are offered to referring physicians. The terms on which investment interests are offered to physicians must not be related to the past or expected volume of referrals or other business from the physicians.

2. There is no requirement that any physician investor make referrals to the entity or otherwise generate business as a condition for remaining an investor.

3. The entity must not market or furnish its name or services to referring physician investors differently than to other investors.

4. The entity must not loan funds or guarantee a loan for physicians in a position to refer to the entity.

5. The return on the physician's investment must be tied to the physician's equity in the facility, rather than to the volume of referrals.

6. Investment contracts should not include "non-competition clauses" that prevent physicians from investing in other facilities.

7. Physicians must disclose their investment interest to their patients when making a referral. Patients must be given a list of effective alternative facilities if any such facilities become reasonably available, informed that they have the option to use one of the alternative facilities, and assured that they will not be treated differently by the physician if they do not choose the physician-owned facility. These disclosure requirements also apply to physician investors who directly provide care or services to their patients in facilities outside their office practice.

8. The physician's ownership interest should be disclosed, when requested, to third-party payers.

9. An internal utilization review program must be established to ensure that investing physicians do not exploit their patients in any way, as by inappropriate or unnecessary utilization.

10. When a physician's financial interest conflicts so greatly with the patient's interest as to be incompatible, the physician must make alternative arrangements for the care of the patient.

C. With regard to physicians who invested in facilities under the council's prior opinion, it is recommended that they reevaluate their activity in accordance with this opinion and comply with the guidelines to the fullest extent possible. If compliance with the need and alternative investor criteria

investor is not practical, it is essential that the identification of reasonably available alternative facilities be provided.

8.04 CONSULTATION. Physicians should obtain consultation whenever they believe that it would be helpful in the care of the patient or when requested by the patient or the patient's representative. When a patient is referred to a consultant, the referring physician should provide a history of the case and such other information as the consultant may need, and the consultant should advise the referring physician of the results of the consultant's examination and recommendations relating to the management of the case as soon as possible. (V)

8.05 CONTINGENT PHYSICIAN FEES. A physician's fee for services should be based on the value of the service provided by the physician and should not be contingent on the outcome. (VI)

8.06 CONTRACTUAL RELATIONSHIPS. The contractual relationships that physicians assume when they enter prepaid group practice plans are varied.

Income arrangements may include hourly wages for physicians working part-time, annual salaries for those working full-time, and share of group income for physicians who are partners in groups that are somewhat autonomous and contract with plans to provide the required medical care. Arrangements also usually include a range of fringe benefits, such as paid vacations, insurance, and pension plans.

Physicians may work directly for plans or may be employed by the medical group or the hospital that has contracted with the plan to provide services. The WSMA recognizes that under proper legal authority such plans may be established and a physician may be employed by, or otherwise serve, a medical care plan. In the operation of such plans, physicians should not be subjected to lay interference in professional medical matters, and their primary responsibility should be to the patients they serve. (VI)

8.07 DRUGS AND DEVICES: PRESCRIBING. It is unethical for a physician to be influenced in the prescribing of drugs or devices by his direct or indirect financial interest in a pharmaceutical firm or other supplier. It is immaterial whether the firm manufactures or repackages the products involved.

It is unethical for a physician to own stock or have a direct or indirect financial interest in a firm that uses its relationship with physicians-stockholders as a means

of inducing or influencing them to prescribe the firm's products. Practicing physicians should divest themselves of any financial interest in firms that use this form of sales promotion. Reputable firms rely on quality and efficacy to sell their products under competitive circumstances, not on appeal to physicians with financial involvement which might influence them in their prescribing.

It cannot be considered unethical for a physician to own or operate a pharmacy provided there is not exploitation of his patient.

The physician is permitted to exercise his own best judgment when caring for his patients. There will be situations when it is necessary or desirable for a physician to dispense or supply what he has prescribed. The Principles permit this to be done. A physician in the exercise of sound discretion may dispense "in the best interest of his patient"; he may not dispense solely for his convenience or solely for the purpose of supplementing his income.

Physicians who enter into agreements, the purposes of which are to restrict free choice or gain material advantage, are guilty of unethical practices. It is also unethical for physicians to use prescription blanks with the name of a pharmacy printed thereon. A patient is entitled to a copy of his or her prescription for glasses, drugs, or appliances, and he has the privilege of having the prescription filled wherever he wishes.

The principle of free choice applies as well to the choice of a pharmacy. Accordingly, the Council looks with disfavor upon the use of direct telephone lines between a physician and a pharmacist on the theory that a patient is entitled to a written prescription which he can take to the pharmacist of his choice. (I, II, III, IV, V)

8.08 GIFTS TO PHYSICIANS FROM INDUSTRY. Many gifts to physicians by companies in the pharmaceutical, device and medical equipment industries serve an important and socially beneficial function. For example, companies have long provided funds for educational seminars and conferences. However, there has been growing concern about certain gifts from industry to physicians. Some gifts that reflect customary practices of industry may not be consistent with principles of medical ethics. To avoid the acceptance of inappropriate gifts, physicians should observe the following guidelines:

1. Any gifts accepted by physicians individually should primarily entail a benefit to patients and should not be of substantive value. Accordingly, textbooks, modest meals and other gifts are appropriate if they serve a genuine educational function. Cash payments should not be accepted.

2. Individual gifts of minimal value are permissible as long as the gifts are related to the physician's work (e.g., pens and notepads).

3. Subsidies to underwrite the costs of continuing medical education conferences or professional meetings can contribute to the improvement of patient care and therefore are permissible. Since the giving of a subsidy directly to a physician by a company's sales representative may create a relationship which could influence the use of the company's products, any subsidy should be accepted by the conference's sponsor who in turn can use the money to reduce the conference's registration fee. Payments to defray the costs of the conference should not be accepted directly from the company by the physicians attending the conference.

4. Subsidies from industry should not be accepted to pay for the costs of travel, lodging or other personal expenses of physicians attending conferences or meetings, nor should subsidies be accepted to compensate for the physicians' time. Subsidies for hospitality should not be accepted outside of modest meals or social events held as a part of the conference or meeting. It is appropriate for faculty at conferences or meetings to accept reasonable honoraria and to accept reimbursement for reasonable travel, lodging and meal expenses. It is also appropriate for consultants who provide genuine services to receive reasonable compensation and to accept reimbursement for reasonable travel, lodging and meal expenses. Token consulting or advisory arrangements cannot be used to justify compensating physicians for their time or their travel, lodging and other out-of-pocket expenses.

5. Scholarships or other special funds to permit medical students, residents and fellows to attend carefully selected educational conferences may be permissible as long as the selection of students, residents or fellows who will receive the funds is made by the academic or training institution.

6. No gifts should be accepted if there are strings attached. For example, physicians should not accept gifts if they are given in relation to the physicians' prescribing practices. In addition, when companies underwrite medical conferences or lectures other than their own, responsibility for and control over the selection of content, faculty, educational methods and materials should belong to the organizers of the conferences or lectures.

8.09 INFORMED CONSENT. The patient's right of self-decision can be effectively exercised only if the patient possesses enough information to enable an intelligent choice. The patient should make his own determination on treatment. Informed

consent is a basic social policy for which exceptions are permitted: 1) where the patient is unconscious or otherwise incapable of consenting and harm from failure to treat is imminent; or 2) when risk-disclosure poses such a serious psychological threat of detriment to the patient as to be medically contraindicated. Social policy does not accept the paternalistic view that the physician may remain silent because divulgence might prompt the patient to forego needed therapy. Rational, informed patients should not be expected to act uniformly, even under similar circumstances, in agreeing to or refusing treatment. (I, II, III, IV, V)

8.10 LABORATORY SERVICES.

1) A physician should not misrepresent or aid in the misrepresentation of laboratory services performed and supervised by a non-physician as the physician's professional services. Such situations could involve a laboratory owned by a physician who directs and manages its financial and business affairs with no professional medical services being provided; laboratory work being performed by technicians and directly supervised by a medical technologist with no participation by the physician; or the physician's name being used in the connection with the laboratory so as to create the appearance that it is owned, operated, and supervised by a physician when this is not so.

2) If a laboratory is owned, operated, and supervised by a non-physician in accordance with state law and performs tests exclusively for physicians who receive the results and make their own medical interpretations, the following considerations would apply:

The physician's ethical responsibility is to provide his patients with high-quality services. This includes services which he performs personally and those which he delegates to others. A physician should not utilize the services of any laboratory, irrespective of whether it is operated by a physician or non-physician, unless he has the utmost confidence in the quality of its services. He must always assume personal responsibility for the best interests of his patients. Medical judgment based upon inferior laboratory work is likewise inferior. Medical considerations, not cost, must be paramount when a physician chooses a laboratory. The physician who disregards quality as the primary criterion or who chooses a laboratory solely because it provides him with low-cost laboratory services on which he charges the patient a profit, is not acting in the best interests of his patient. However, if reliable, quality laboratory services are available at a lower cost, the patient should have the benefit of the

savings. As a professional, the physician is entitled to fair compensation for his services. A physician should not charge a mark-up, commission, or profit on the services rendered by others. A physician should not charge for services that are not provided. A mark-up is an excessive charge that exploits patients if it is nothing more than a tacked-on amount for a service already provided and accounted for by the laboratory. A physician may make an acquisition charge or processing charge. The patient should be notified of any such charge in advance.

3) It is unethical for two or more physicians to secretly split or share the fees that have been given by a patient supposedly as reimbursement for the service of one man alone. When it is more practical for the physician to include the laboratory charge in his own statement, the physician's bill to the patient should indicate the charges apart from the charges for his own professional services (see Section 6.06). (I, II, III, IV, V)

8.11 LIEN LAWS. It is not improper for a physician to use a physicians' lien law as a means of assuring payment of his fee, provided his fee is fixed in amount and not contingent on the amount of settlement of the patient's claim against a third party. (I, VI)

8.12 NEGLECT OF PATIENT. Physicians are free to choose whom they will serve. The physician should, however, respond to the best of his ability in cases of emergency where first aid treatment is essential. Once having undertaken a case, the physician should not neglect the patient, nor withdraw from the case without giving notice to the patient, the relatives, or responsible friends sufficiently long in advance of withdrawal to permit another medical attendant to be secured.

8.13 PATIENT INFORMATION. The physician must properly inform the patient of the diagnosis and of the nature and purpose of the treatment undertaken or prescribed. The physician may not refuse to so inform the patient. (I, V)

8.14 SECOND OPINIONS. Physicians should recommend that a patient obtain a second opinion whenever they believe it would be helpful in the care of the patient. When recommending a second opinion, physicians should explain the reasons for the recommendation and inform their patients that patients are free to choose a second-opinion physician on their own or with the assistance of the first physician. Patients

are also free to obtain second opinions on their own initiative, with or without their physician's knowledge.

With the patient's consent, the first physician should provide a history of the case and such other information as the second-opinion physician may need. The second-opinion physician should maintain confidentiality of the evaluation and should report to the first physician if the consent of the patient has been obtained.

After evaluating the patient, a second-opinion physician should provide the patient with a clear understanding of the opinion, whether or not it agrees with the recommendations of the first physician.

When a patient initiates a second opinion, it is inappropriate for the primary physician to terminate the patient-physician relationship solely because of the patient's decision to obtain a second opinion.

In some cases, patients may ask the second-opinion physician to provide the needed medical care. In general, second-opinion physicians are free to assume responsibility for the care of the patient. It is not unethical to enter into a patient-physician relationship with a patient who has been receiving care from another physician. By accepting second-opinion patients for treatment, physicians affirm the right of patients to have free choice in the selection of their physicians.

There are situations in which physicians may choose not to treat patients for whom they provide second opinions. Physicians may decide not to treat the patient in order to avoid any perceived conflict of interest or loss of objectivity in rendering the requested second opinion. However, the concern about conflicts of interest does not require physicians to decline to treat second-opinion patients. This inherent conflict in the practice of medicine is resolved by the responsible exercise of professional judgment.

Physicians may agree not to treat second-opinion patients as part of their arrangements with insurers or other third-party payers. Physicians who enter into such contractual agreements must honor their commitments.

Physicians must decide independently of their colleagues whether to treat second-opinion patients. Physicians may not establish an agreement or understanding among themselves that they will refuse to treat each others' patients when asked to provide a second opinion. Such agreements compromise the ability of patients to receive care from the physicians of their choice and are therefore not only unethical but also unlawful.

8.15 SUBSTITUTION OF SURGEON WITHOUT PATIENT'S KNOWLEDGE OR CONSENT. To have another physician operate on one's patient without the patient's knowledge and consent is a deceit. The patient is entitled to choose his own physician, and he should be permitted to acquiesce in or refuse to accept the substitution.

The surgeon's obligation to the patient requires him to perform the surgical operation: 1) within the scope of authority granted by the consent to the operation; 2) in accordance with the terms of the contractual relationship; 3) with complete disclosure of all facts relevant to the need and the performance of the operation; and 4) to utilize his best skill in performing the operation.

It should be noted that it is the operating surgeon to whom the patient grants consent to perform the operation. The patient is entitled to the services of the particular surgeon with whom he or she contracts. The surgeon, in accepting the patient, is obligated to utilize his personal talents in the performance of the operation to the extent required by the agreement creating the physician-patient relationship. He cannot properly delegate to another the duties which he is required to perform personally.

Under normal and customary arrangement with private patients, and with reference to the usual form of consent to operation, the surgeon is obligated to perform the operation, and may use the services of assisting residents or other assisting surgeons to the extent that the operation reasonably requires the employment of such assistance. If a resident or other physician is to perform the operation under the guidance of the surgeon, it is necessary to make a full disclosure of this fact to the patient, and this should be evidenced by an appropriate statement contained in the consent.

If a surgeon employed merely assists the resident or other physician in performing the operation, it is the resident or other physician who becomes the operating surgeon. If the patient is not informed as to the identity of the operating surgeon, the situation is "ghost surgery".

An operating surgeon is construed to be a performing surgeon. As such, his duties and responsibilities go beyond mere direction, supervision, guidance, or minor participation.

The physician is not employed merely to supervise the operation. He is employed to perform the operation. He can properly utilize the services of an assistant to assist in the performance of the operation, but he is not performing the operation where his active participation consists merely of guidance or standby responsibilities in the case of an emergency. (I, II, IV, V)

8.16 TREATMENT OF IMMEDIATE FAMILY MEMBERS.

1. Physicians generally should not treat themselves or members of their immediate families. Professional objectivity may be compromised when an immediate family member or the physician is the patient; the physician's personal feelings may unduly influence his or her professional judgment, thereby interfering with the care being delivered. Physicians may fail to probe sensitive areas when taking the medical history or may fail to perform intimate parts of the physical examination. Similarly, patients may feel uncomfortable disclosing sensitive information or undergoing an intimate examination when the physician is an immediate family member. This discomfort is particularly the case when the patient is a minor child, and sensitive or intimate care should be especially avoided for such patients. When treating themselves or immediate family members, physicians may be inclined to treat problems that are beyond their expertise or training. If tensions develop in a physician's professional relationship with a family member, perhaps as a result of a negative medical outcome, such difficulties may be carried over into the family member's personal relationship with the physician.

2. Concerns regarding patient autonomy and informed consent are also relevant when physicians attempt to treat members of their immediate family. Family members may be reluctant to state their preference for another physician or decline a recommendation for fear of offending the physician. In particular, minor children will generally not feel free to refuse care from their parents. Likewise, physicians may feel obligated to provide care to immediate family members even if they feel uncomfortable providing care.

3. It would not always be inappropriate to undertake self-treatment or treatment of immediate family members. In emergency situations or isolated settings where there is no other qualified physician available, physicians should not hesitate to treat themselves or family members until another physician becomes available. In addition, while physicians should not serve as a primary or regular care provider for immediate family members, there are situations in which routine care is acceptable for short-term, minor problems.

4. Except in emergencies, it is not appropriate for physicians to write prescriptions for controlled substances for themselves or immediate family members.

8.17 SALE OF HEALTH-RELATED GOODS FROM PHYSICIANS' OFFICES

"Health-related products" are any products that, according to the manufacturer or distributor, benefit health. "Selling" refers to the activity of dispensing items that

are provided from the physician's office in exchange for money and also includes the activity of endorsing a product that the patient may order or purchase elsewhere that results in direct remuneration for the physician.

Physicians who engage in in-office sales practices should be aware of related guidelines presented in Judicial Council Opinions 2.16 (Secret Remedies), 2.18 (Unnecessary Services), 2.19 (Worthless Services), 3.01 (Nonscientific Practitioners), 8.03 (Conflict of Interest - Physician Self-referral), and 8.07 (Drugs and Devices: Prescribing).

The primary obligation of physicians is to serve the interests of their patients. In-office sale of health-related products by physicians may present a conflict of interest, could risk placing undue pressure on the patient, and could erode patient trust. When these items offer some health-related benefits, the physician's influence over the sale is amplified and makes it even more necessary for physicians to be cognizant of their special relationship with their patients.

Physicians who do sell health-related products from their offices should not sell any health-related goods whose claims lack scientific validity. Physicians should rely on peer-reviewed literature and other unbiased sources that review evidence in a sound, systematic fashion when judging the efficacy of the product.

Physicians who sell health-related products from their offices should follow these guidelines to limit their conflicts of interest, minimize the risk of brand endorsement, and ensure a focus on benefits to patients.

a) Physicians may distribute health-related products to their patients in order to make useful products readily available to those patients who may benefit from the use of such products. Recommendations to use a product must be made in the patient's best interest, not solely to supplement the physician's income.

b) Physicians must disclose fully the nature of their financial arrangement with a manufacturer or supplier to sell health-related products. Disclosure includes informing patients of financial interests as well as about the availability of the product or other equivalent products elsewhere. Disclosure can be accomplished through face-to-face communication or by posting an easily understood written notification in a prominent location that is accessible by all patients in the office. In addition, physicians should, upon request, provide patients with understandable literature that relies on scientific standards in addressing the validity of the health-related goods.

8.18 SALE OF NON-HEALTH RELATED GOODS FROM PHYSICIANS' OFFICES

1. Physicians should not sell non-health related goods from their offices or other treatment settings, with the exception noted below.

2. Physicians may sell low-cost non-prescription goods from their offices for the profit of community organizations, provided that a) the goods in question are low-cost, b) the physician takes no share in profit from their sale, c) such sales are not a regular part of the physician's business, d) sales are conducted in a dignified manner, and e) sales are conducted in such a way as to assure that patients are not pressured into making purchases.

8.19 ETHICAL PRINCIPLES AND MANAGED CARE

1. Physicians understand that they work exclusively for their patients, not for the patient's employers, family or insurer, regardless of the source of payment for the physician's services. Even if the physician is employed by a third party, medical decisions must always be based solely upon the needs of the patient, not the dictates or practice guidelines offered by the physician's employer. If the physician is substituting his employer's judgment for his own, the patient must be fully informed of this fact.

2. Physicians must inform patient about the specifics of any financial incentives or penalties which may create a conflict of interest or the appearance of a conflict of interest on the part of the physician.

3. Patients must be fully informed about the best available modes of diagnosis and treatment regardless of the stance of their insurer or the financial consequences for the physician. If their insurance company will not allow or pay for the best treatment or evaluation mode, the physician must present the available options to the patient and explain how they very from the best available treatment or evaluation mode.

4. Physicians are ethically bound to be the advocates for their patients, both medically and within the managed care system. If the patient's insurance refuses to support the best available care, the physician must appeal the decision and press the managed care company to provide the optimal care alternative. If the company refuses, the physician must inform the patient that less than optimal care is being provided because of outside restraints. Physicians should not act as surrogates for any insurance or other corporate entity if this will result in less than optimal care for their patient. If someone

other than the physician is making the medical decisions, the patient must be informed.

5. Physicians must limit their patient panel to a size that allows them to provide timely and professional care for all of their patients, including patients who require urgent or emergent care. It is inappropriate for physicians to enlarge their practices to the point at which their patient care may become hurried, unprofessional or inattentive.

6. Physicians should not sign contracts with their employers or any insurance or managed care company unless they would be willing to disclose to their patients the details of these agreements involving the financial incentives and penalties for reducing the availability or cost or care. Physicians should oppose and refuse to sign any contractual agreement which might reasonable be expected to reduce the availability or quality of care provided to their patients. Physicians must not sign any contract containing a "gag" clause that prevents the physician from discussing alternative diagnostic or treatment options frowned upon by the managed care company.

9.00 OPINIONS ON PROFESSIONAL RIGHTS AND RESPONSIBILITIES

9.01 ACCREDITATION. Physicians who engage in activities that involve the accreditation, approval, or certification of institutions, facilities, and programs that provide patient care or medical education or certify the attainment of specialized professional competence have the ethical responsibility to apply standards that are relevant, fair, reasonable, and nondiscriminatory. The accreditation of institutions and facilities that provide patient care should be based upon standards that focus upon the quality of patient care achieved. Standards used in the accreditation of patient care and medical education, or the certification of specialized professional attainment should not be adopted or used as a means of economic regulation. (I, IV, VII)

9.02 AGREEMENTS RESTRICTING THE PRACTICE OF MEDICINE. There is no ethical proscription against suggesting or entering into a reasonable agreement not to practice within a certain area for a certain time, if it is knowingly made, understood, and consistent with local law. Whether it is advisable as being in the best interest of the public depends on all of the surrounding facts. (VI, VII)

9.03 CIVIL RIGHTS AND PROFESSIONAL RESPONSIBILITY. The Washington State Medical Association is in favor of equality of opportunity in medical society activities, medical education and training, employment, and all other aspects of medical professional endeavors regardless of race, color, religion, creed, ethnic affiliation, national origin, or sex.

The Washington State Medical Association is unalterably opposed to the denial of membership privileges and responsibilities in county medical societies and state medical associations to any duly licensed physician because of race, color, religion, creed, ethnic affiliation, national origin, or sex.

The Washington State Medical Association calls upon the medical profession and all individual members of the Washington State Medical Association to exert every effort to end any instances in which such equal rights, privileges, or responsibilities are denied. (III, IV, VII)

9.04 DISCIPLINE AND MEDICINE. A physician should expose, without fear or favor, incompetent or corrupt, dishonest, or unethical conduct on the part of members of the profession. Questions of such conduct should be considered, first, before proper medical tribunals in executive sessions or by special or duly appointed committees on ethical relations, provided such a course is possible and provided, also, that the law is not hampered thereby. If doubt should arise as to the legality of the physician's conduct, the situation under investigation may be placed before officers of the law, and the physician-investigators may take the necessary steps to enlist the interest of the proper authority.

An ethical physician will observe the laws regulating the practice of medicine and will not assist others to evade such laws.

The Judicial Council cannot pass judgment in advance on a situation that may later come before it on appeal. The Judicial Council cannot be an attorney for a society or a member thereof and later judge in the same factual situation. The local medical society has the initial obligation of determining all the facts and whether or not disciplinary action is indicated. Questions asking for a review of a proposed course of action or an evaluation of an existing factual situation should be presented to the appropriate official of the physician's local society. (II, III, VII)

9.05 DUE PROCESS. The basic principles of a fair and objective hearing should always be accorded to the physician whose professional conduct is being reviewed. The fundamental aspects of a fair hearing are: a listing of specific charges, adequate notice of the right to a hearing, the opportunity to be present and to rebut the

evidence, and the opportunity to present a defense. These principles apply when the hearing body is a medical society tribunal or a hospital committee composed of physicians.

These principles of fair play apply in all disciplinary hearings and in any other type of hearing in which the physician may be deprived of valuable property rights. Whenever physicians sit in judgment on physicians and whenever that judgment affects a physicians reputation, professional status, or livelihood, these principles of fair play must be observed.

All physicians are urged to observe diligently these fundamental safeguards of due process whenever they are called upon to serve on a committee which will pass judgment on physicians. Medical societies and hospital medical staffs are urged to review the constitution and bylaws of the society or hospital medical staff to make sure that these instruments provide for such procedural safeguards. (II, III, VII)

9.06 ENTERTAINING EXPENSES. There are circumstances in which a physician may ethically entertain other physicians. The propriety of such matters must be determined on a case-by-case basis.

9.07 FREE CHOICE. Free choice of physicians is the right of every individual. The individual may select and change at will the physicians who serve him, or he may choose a medical care plan such as that provided by a closed panel or group practice, or he may choose to obtain medical care by becoming a subscriber of a health maintenance or service organization. The freedom of the individual to select his preferred system of medical care and free competition among physicians and alternative systems of medical care are prerequisites of ethical practice and optimal medical care.

In choosing to subscribe to a health maintenance or service organization or in choosing or accepting treatment in a particular hospital, the patient is thereby accepting limitations upon free choice of medical services.

The need of an individual for emergency treatment in cases of accident or sudden illness may, as a practical matter, preclude free choice of physician, particularly where there is loss of consciousness.

Although the concept of free choice assures that an individual can generally choose a physician, likewise a physician may decline to accept that individual as a patient. In selecting the physician of choice, the patient may sometimes be obliged to pay for medical services which might otherwise be paid by a third party. (VI)

9.08 PATENT FOR SURGICAL OR DIAGNOSTIC INSTRUMENT. A physician may patent a surgical or diagnostic instrument he has discovered and developed. The laws governing patents are based on the sound doctrine that one is entitled to protect his discovery. (V, VII)

9.09 PEER REVIEW. Medical society ethics committees, hospital credentials and utilization committees, and other forms of peer review have been long established by organized medicine to scrutinize physicians' professional conduct. At least to some extent, each of these types of peer review can be said to impinge upon the absolute professional freedom of physicians. They are, nonetheless, recognized and accepted. They are necessary. They balance the physician's right to exercise his medical judgment freely with his obligation to do so wisely and temperately. (II, III, VII)

9.10 PHYSICIAN RIGHTS AND RESPONSIBILITIES.

1) I intend to use my skill, training, and experience to the utmost for your benefit.

2) My staff and I attempt to treat you with the same courtesy, respect, and consideration that I expect for myself or family.

3) My fees are usual and customary for my specialty in our area, except by prior agreement between us to the contrary. You are invited to discuss charges for proposed methods of treatment. If you do not understand my charges, please ask me or my staff.

4) I try to be on time for appointments scheduled with you.

5) It is my custom and intent to explain to you the nature of your illness, the relevant choices of management, and the likely risks.

6) I keep professional notes and records of your medical condition. At your written request, I will transmit a copy of your record, or a summary thereof, to subsequent attending physicians designated by you, or to designated third parties.

7) I hold your medical record confidential, and except with your permission, or upon court order, I do not release it. I will make copies of your medical record available or provide you with excerpts of it, when not prohibited by law or when not harmful to your medical interests.

8) I limit my practice to those patients I am best able to serve within the limits of my training, time, and energy.

9) I will refer you for consultation with other physicians when I consider their services will be helpful, or upon your request.

10) I will transfer responsibility for your care to another physician when this appears to be for your benefit, or upon your request.

11) I will not subject you to investigative or research or teaching studies or exercises without your consent.

12) I ask you to tell me the truth regarding your illness.

13) I ask you to provide basic data necessary for proper record keeping.

14) I ask you to keep appointments, treat my staff with courtesy, and follow my instructions with care.

9.11 PROFESSIONAL CORPORATIONS. It is ethically permissible for physicians to form professional corporations. The ethical principles for the medical practice conducted under the form of a professional service corporation are exactly the same as for the individual physician. The professional service corporation and each physician member of the professional service corporation should observe the Principles of Medical Ethics.

9.12 REFUSAL TO SERVE A CLASS OF PATIENTS. The ethical physician shall not refuse treatment to any class of patients based solely upon their race, religion, sex, or national origin. The choice of patients is left up to the individual physician and vice versa provided there is not neglect or abandonment. However, it is unethical for an individual physician or a group of physicians to refuse to serve a class of patients, per se.

There is no ethical restraint on individual physicians or groups of physicians pointing out to directors of programs such as Medicaid, that program restrictions (substandard fees, restrictions on services, etc.) have an inevitable effect on the

choice of patients made by the individual physician. However, pronouncements by an individual physician or by a group of physicians stating they would not serve a class of patients would be unethical.

9.13 REPORTING IMPAIRED, INCOMPETENT OR UNETHICAL COLLEAGUES. Physicians have an ethical obligation to report impaired, incompetent, and unethical colleagues.

1. Impairment

A. Impairment should be reported to the hospital's in-house impairment program, if available. If no in-house program is available, or the type of impairment is normally addressed by an impairment program, e.g. extreme fatigue and emotional distress, then the chief of an appropriate clinical service, chief of staff of the hospital, or other appropriate supervisor should be alerted.

B. If a report cannot be made through the usual hospital channels, then a report should be made to the Washington State Physician Health Program (formerly the Monitored Treatment Program).

C. Physicians in office-based practices who do not have clinical privileges at an area hospital should be reported directly to the Physician Health Program.

D. If reporting to an individual or program which would facilitate the entrance of the impaired physician into an impaired physician program cannot be accomplished, then the impaired physician should be reported directly to the Washington State Medical Disciplinary Board.

2. Incompetence

A. Initial reports of incompetence should be made to the appropriate clinical authority who would be empowered to assess the potential on patient welfare and to facilitate remedial action (e.g. the chief resident, chief of an appropriate clinical service, chief of the hospital medical staff, medical director of a group practice).

B. The individual who receives a report of incompetence should, in turn, notify the hospital peer review body where appropriate.

Physicians who receive reports of incompetence have an ethical duty to critically and objectively evaluate the reported information and to assure that identified deficiencies are either remedied or further reported to the Medical Disciplinary Board.

C. Instances of incompetence by physicians who have no hospital affiliation should be reported to the appropriate county medical society, the WSMA, or the Medical Disciplinary Board.

D. Continued behavior that is potentially injurious to patients must further be reported to the Medical Disciplinary Board.

E. If the incompetence is of a sufficiently serious nature as to pose an immediate threat to the health of the physician's patients, then it must be reported directly to the Medical Disciplinary Board.

3. Unethical Conduct. Unethical behavior or unprofessional conduct (which does not fit into the category of either incompetence or impairment) should be reported in accordance with these guidelines:

A. Unethical conduct which threatens patient care or welfare shall be reported to the appropriate authority or a particular clinical service (i.e. the chief resident, the chief of an appropriate clinical service, the chief of the hospital staff, or the Medical Disciplinary Board).

B. Unethical behavior which violates the provisions of RCW 18.130.180 (the Uniform Disciplinary Act) should be reported to the Medical Disciplinary Board.

C. Unethical conduct which violates criminal statutes should be reported to the appropriate law enforcement authorities.

D. Examples of unethical conduct which do not fall into the above three categories, or unethical conduct which has not been addressed through other channels should be reported to the local county medical society or the Washington State Medical Association.

4. Where the impairment, incompetence, or unethical behavior of a physician continues despite the initial report(s), the reporting physician should report to the Medical Disciplinary Board. In order to aid physicians who report inappropriate behavior of colleagues in carrying out this obligation, the

person or body receiving the initial report should notify the reporting physician when appropriate action has been taken.

5. RCW 4.24.240, 4.24.250, 18.72.265 and 18.130.070 provides immunity from civil liability for those who report or provide information about impaired, incompetent, or unethical colleagues to appropriate individuals or entities in good faith and without malice.

6. In certain circumstances, an anonymous report may be the only practical method of alerting an authoritative body to a colleague's misconduct. Anonymous reports of misconduct should receive appropriate review and confidential investigation.

7. Principles of due process must be observed in the conduct of all disciplinary matters involving physician participants at all levels. However, the confidentiality of the reporting physician should be maintained to the greatest extent possible within the constraints of due process, in order to minimize potential professional recriminations.

8. The medical profession as a whole must combat the perception that physicians are not adequately protecting the public from incompetent, impaired or unethical physicians by better communicating its efforts and initiatives at maintaining high ethical standards and quality assurance.

9.14 SEXUAL MISCONDUCT IN THE PRACTICE OF MEDICINE.

1. Sexual contact, which occurs concurrent with the physician-patient relationship constitutes sexual misconduct. Sexual or romantic interactions between physicians and patients or key third parties detract from the goals of the physician-patient relationship, may exploit the vulnerability of the patient, may obscure the physician's objective judgment concerning the patient's health care, and ultimately may be detrimental to the patient's well being.

2. If a physician has reason to believe that non-sexual contact with a patient may be perceived as or may lead to sexual contact, then he or she should avoid the non-sexual contact.

3. At a minimum, the physician's ethical duties include terminating the physician-patient relationship before initiating a dating, romantic, or sexual relationship with a patient or a key third party.

4. Sexual or romantic relationships between a physician and a former patient or key third party may be unduly influenced by the previous physician-patient relationship. Sexual or romantic relationships with former patients or key third parties are unethical if the physician uses or exploits trust, knowledge, emotions, or influence derived from the previous professional relationship.

5. Key third parties include, but are not limited to, spouses or partners, parents, siblings, children, guardians, and proxies.

9.15 EXPERT WITNESS STANDARDS.

Qualifications

1. Possess a current, valid and unrestricted license in the state in which he/she practices.

2. Fully trained in the specialty and a diplomat in a relevant ABMS recognized specialty board and demonstrated competence in the subject of the case.

3. Be familiar with the clinical practice of the specialty or the subject matter of the case, and be actively involved in the clinical practice of the specialty for at least 3 of the previous 5 years at the time of the testimony.

Standards For Testimony

1. Thoroughly review the medical information in the case and testify to its content fairly and impartially.

2. Review the standards of practice prevailing at the time of the occurrence.

3. Be prepared to state the basis of the testimony presented, and whether it is based on personal experience, specific clinical references, or generally accepted opinion in the specialty field.

4. The expert witness is expected to be impartial, and should not adopt a position as an advocate.

5. Compensation should be reasonable and commensurate with the time and effort given to preparing for deposition and court appearance. An expert witness may not link compensation to outcome of the case.

6. Testimony is public record and subject to peer review.

7. Make a clear distinction between malpractice and adverse outcomes. Assess the relationship of the alleged substandard practice to the patient's outcome.

APPENDIX 1

Washington State Medical Association
Constitution

ARTICLE XII -- JUDICIAL COUNCIL

Section 1. Composition. The Judicial Council shall be composed of ten (10) members, each of whom shall be a member of the Association in good standing. Members shall be chosen to maintain the spirit of geographic and specialty diversity. No member of the Judicial Council shall, during his tenure of office, hold the office of WSMA President, President-Elect, Vice President, Secretary-Treasurer, Immediate Past President, Speaker of the House of Delegates, or Vice Speaker of the House of Delegates of this Association. Any member of the Council who also is a member of an Ethics, Grievance, or Mediation Committee, or member of the Governing Board of a component county society, which serves in these capacities, shall not, as a Councilor, participate in deliberations pertaining to a question involving a member of the component county society or cast a vote in respect thereto.

Section 2. Nomination and Election. The Judicial Council shall be nominated by the president and elected by the Board of Trustees for one term of five years or completion of one term with the election subject to ratification by a two-thirds vote of the House of Delegates at the next annual meeting following the Board of Trustees meeting at which the election is held. The term of a Judicial Council member shall remain in effect through the last meeting of the House of Delegates at which time the newly ratified member's term will begin. The initial election shall be arranged so that at each annual session, the term of two members expires. No Council member shall serve more than one term.

Ratification of the election of Council members by the House of Delegates should be given at the opening session of the House of Delegates.

The president shall submit nominations for the Judicial Council to the Board of Trustees at least 30 days prior to their election. Component county societies, state specialty societies, special sections, other organizations represented in the House of Delegates, and members of the Board of Trustees may submit the names and qualifications of candidates for consideration by the President.

Members of the Judicial Council must be active members, have been members of this association for 10 years, and of outstanding ethical and professional character.

Section 3. Vacancies. Whenever a vacancy occurs as a result of the death or resignation of a Judicial Council member, or from any other cause, the Board of Trustees shall have the authority to fill a vacancy on the Judicial Council until that election can be ratified at the next meeting of the WSMA House of Delegates.

Section 4. Meetings of the Judicial Council. The Judicial Council shall meet as soon as possible after each annual meeting of the House of Delegates at which new Council members are ratified. At such meetings, the Council shall select a Chair, Vice-Chair, and such other officers as may be deemed desirable. The terms of such officers and their duties and responsibilities shall be determined by the Judicial Council.

Section 5. Authority. The Judicial Council is the judicial authority of the Association and its judicial interpretations shall be final except as provided for in Article XII, Sections 9 and 11.

Section 6. Functions. The functions of the Judicial Council are:

(a) to interpret the Principles of Medical Ethics of the Association.

(b) to interpret the Bylaws of the Association.

(c) To investigate general ethical conditions and all matters pertaining to the relations of physicians to one another or to the public, and make recommendations to the House of Delegates or the component county societies.

(d) to receive appeals filed by applicants who allege that they, because of color, creed, race, religion, ethnic origin, national origin, or sex, have been unfairly denied membership in a component county society, to determine the facts in the case, and to report the findings to the House of Delegates. If the Council determines that the allegations are indeed true, it shall admonish, censure, or in the event of repeated violations, recommend to the House of Delegates that the component county society involved be declared to be no longer a component member of the Association.

(e) To request the President to appoint investigating juries to which it may refer complaints or evidences of unethical conduct which in its judgment are of greater than local concern. Such investigative juries, if probable cause for action be shown, shall submit formal charges to the President, who shall appoint a prosecutor to prosecute such charges against the accused before the council on Ethical and Judicial Affairs in the name and on behalf of the American Medical Association. The Council may acquit, admonish, suspend or expel the accused.

Section 7. Original Jurisdiction. The Judicial Council shall have original jurisdiction in:

(a) all questions involving membership.

(b) all controversies arising under these Bylaws and under the Principles of Medical Ethics to which the Association is a party.

(c) controversies between two or more component county societies or their members.

Section 8. Appellate Jurisdiction. The Judicial Council shall have appellate jurisdiction in questions of law and procedure but not of fact in all cases which arise:

(a) Between a component county society and one or more of its members.

(b) Between a member or members and the component county society to which said member or members belong following an appeal.

Section 9. Appeal Mechanisms. Notice of appeal shall be filed with the Council within thirty (30) days of the date of the decision by the component county society and the appeal shall be perfected within sixty (60) days thereof; provided however, that the Council may grant, for what it considers good and sufficient cause, an additional thirty (30) days for perfecting the appeal.

Section 10. Annual Reports. The Council shall report annually to the WSMA House of Delegates an appropriate summary of the actions of the Council along with recommendations for consideration by the House of Delegates.

Section 11. Action on Opinions. Opinions of the Judicial Council may be returned to the Judicial Council for reconsideration by majority vote of the Board of Trustees or the House of Delegates or may be rescinded by a three-fourths vote of the House of Delegates.

Section 12. Confidentiality. The charges and the record of all proceedings of the Council shall be held confidential, except where fulfillment of the decision of the Council shall require otherwise.

APPENDIX 2

Washington State Medical Association

RULES OF THE WSMA JUDICIAL COUNCIL REGARDING APPEALS

I. The method provided by these rules for appealing cases to the WSMA Judicial Council and for securing a review of the same, shall be exclusive and shall supersede all other methods heretofore provided.

II. In these rules, unless the context or subject matter otherwise requires:

A. The past, present and future tenses shall each include the other; and the singular and plural number shall each include the other.

B. The words "component society" shall mean the chartered county society from which a case is appealed.

C. The party appealing is known as the "appellant," and the adverse party as the "respondent."

D. The words "shall" and "must" are mandatory, and the word "may" is permissive.

E. "Judgment" means any judgment, order, ruling or decree of a component society from which an appeal lies.

III. The time within which acts are to be done, as provided in these rules, shall be computed by excluding the first and including the last day. If the last day is a Saturday or Sunday or a holiday, the act must be completed on the next business day.

IV. In order to perfect an appeal with the Judicial Council, the party appealing must exhaust all other remedies provided within his component society.

V. Any party aggrieved by the judgment of a component society may appeal to the Judicial Council within 30 days following the date of such judgment for a determination of questions of law and procedure, but not of fact. The appeal shall be in writing and must be filed with the Chairman of the Judicial Council.

VI. Upon filing of the appeal, the members of the Judicial Council will be notified and a time for oral argument will be set should a majority of the Council determine that oral argument is warranted. Should oral argument be warranted, the appellant and the respondent shall be afforded at least 30 days notice prior to the date set for argument.

VII. The record to be reviewed by the Judicial Council shall consist of:

A. A transcript of proceedings, if available;

B. Original papers filed by the parties; and

C. Exhibits.

The duty to prepare and submit the record shall be that of the appellant unless otherwise agreed upon by the parties.

Should the appellant prevail on his appeal to the Judicial Council, the local county medical society involved shall reimburse him for preparation of the transcript of proceedings necessary for the appeal.

VIII. The Judicial Council may, on its own initiative, direct that additional information be provided to it prior to rendering a decision.

IX. The Judicial Council may request that written briefs be submitted to it concerning the issues of law or procedure to be reviewed. The request shall be in writing, will specify the issues to be addressed, and will be mailed to the parties at least 15 days prior to oral argument.

X. Any briefs requested shall be filed with the Chairman of the Judicial Council at least ten days prior to the date set for oral argument.

XI. Oral argument may be presented by either a party or his attorney. Each side is allowed 30 minutes for oral argument. The appellant is entitled to open and conclude oral argument.

XII. All efforts at conciliation and compromise will be exerted by the Judicial Council prior to oral argument.

XIII. The Judicial Council may reverse, affirm or modify the judgment of the component society and take any other action as the merits of the case and the interest of justice may require. The Council may reverse the decision of the component society if the substantial rights of the appellant may have been prejudiced because the findings, conclusions, or decisions of the component society are arbitrary or capricious.

XIV. The decision of the Judicial Council shall be in writing, signed by the Council members joining in the same. A majority of the Council must join in the decision. A dissenting or concurring opinion may be filed by an individual Council member if desired.

XV. The decision of the Judicial Council shall be final and bind the parties to the appeal.

XVI. The written opinion of the Judicial Council shall be disseminated to the parties to the appeal and a copy will be placed in the permanent files of the Council. The confidentiality of the records and opinions will be presented.

XVII. A party may file a motion for reconsideration of the decision of the Judicial Council. The motion must be filed in the same manner as set out in these rules for an appeal except that the motion be filed within ten days after the decision of the Council. The motion should state with particularity the points which the moving party contends the Council has overlooked or misapprehended, together with a brief argument on the points raised.

XVIII. A party may appeal to the AMA under such rules and procedures as adopted by that body.

XIX. The Judicial Council may impose penalties for the violation of or failure to observe these rules.