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AMA CODE SAYS

AMA *Code of Medical Ethics*' Opinions Related to What We Owe Health Care Workers Earning Low Wages

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Abstract

This article applies opinions in the AMA *Code of Medical Ethics* to organizational obligations and interprofessional collaboration in health care, especially concerning workers earning low wages. In particular, it examines what the AMA *Code* says regarding advocacy, discrimination, and collaborative care, as well as the ethical practice environment.

Introduction

The American Medical Association (AMA) *Code of Medical Ethics* offers guidance on topics that can inform physician team and organizational leaders' considerations of what is owed to health workers earning low wages. These topics include recognizing inequity among patient groups and physicians' responsibilities to marginalized patients and physician colleagues. The following examines what the AMA *Code* says about advocacy, discrimination, collaborative care, and the ethical practice environment.

Advocacy

When the AMA *Code* addresses physicians engaging in advocacy efforts, it focuses on the interests of individual patients and physicians' obligation to provide optimal care. (See opinions 11.1.2, "Physician Stewardship of Health Care Resources,"[1] and 11.1.4, "Financial Barriers to Health Care Access,"[2] for example.) When the *Code* speaks to political advocacy to promote systemic change, it merely states:

Physicians who participate in advocacy activities should:

(a) Ensure that the health of patients is not jeopardized and that patient care is not compromised.
(b) Avoid using disruptive means to press for reform. Strikes and other collective actions may reduce access to care, eliminate or delay needed care, and interfere with continuity of care and should not be used as a bargaining tactic. In rare circumstances, briefly limiting personal availability may be appropriate as a means of calling attention to the need for changes in patient care. Physicians should be aware that some actions may put them or their organizations at risk of violating antitrust laws or laws pertaining to medical licensure or malpractice.[3]

This guidance highlights a physician's primary obligation to individual patients, even at the cost of benefiting patient populations or the health care system in the future. In other words, strikes or other large-scale bargaining tactics, which could be used to advocate for higher pay for workers earning low wages but could limit patient access to needed care, are prohibited by the AMA *Code*. However, it's reasonable to interpret this opinion as allowing bargaining tactics that are not expected to interfere with patient care. As we'll see below, other areas of the AMA *Code* encourage physician leaders of health care organizations to implement policies that support the workforce for which they are responsible.

Discrimination

In Opinion 1.1.2, "Prospective Patients," the AMA *Code* makes a fundamental statement that physicians must not discriminate against prospective patients based on protected class.[4] But in Opinion 9.5.4, "Civil Rights and Medical Professionals," the AMA *Code* also addresses not discriminating against individuals entering and moving through the medical profession.

> Opportunities in medical society activities or membership, medical education and training, employment and remuneration, academic medicine and all other aspects of professional endeavors must not be denied to any physician or medical trainee because of race, color, religion, creed, ethnic affiliation, national origin, gender or gender identity, sexual orientation, age, family status, or disability or for any other reason unrelated to character, competence, ethics, professional status, or professional activities.[5]

Along the same lines, the AMA *Code* recognizes the effects of gender discrimination within the physician workforce in Opinion 9.5.5, "Gender Discrimination in Medicine."

> Inequality of professional status in medicine among individuals based on gender can compromise patient care, undermine trust, and damage the working environment. Physician leaders in medical schools and medical institutions should advocate for increased leadership in medicine among individuals of underrepresented genders and equitable compensation for all physicians.[6]

This opinion also outlines specific guidance for physicians to address gender discrimination.

> Collectively, physicians should actively advocate for and develop family-friendly policies that:
> (a) Promote fairness in the workplace, including providing for:
> (i) Retraining or other programs that facilitate re-entry by physicians who take time away from their careers to have a family
> (ii) On-site child care services for dependent children
> (iii) Job security for physicians who are temporarily not in practice due to pregnancy or family obligations[6]

This guidance should be an essential part of any argument to protect all health worker colleagues, especially those of lower status earning low wages.

Collaborative Care and an Ethical Practice Environment

The AMA *Code* offers guidance on collaborative care for physicians working in health care teams that include health care workers who are not necessarily physicians, or even clinicians. In Opinion 10.8, "Collaborative Care," the AMA *Code* recognizes that "teams that collaborate effectively can enhance the quality of care for individual patients."[7] An effective multidisciplinary health care team, the opinion explains, requires an effective physician leader who facilitates decision making aimed at the end goal of efficiency within the group. The main responsibilities of this leader—such as understanding the other team members' skills and expertise; promoting core team values of honesty,

discipline, and commitment to continuous improvement; and generally fostering a team culture in which each member's opinion is heard and considered—are framed within the context of the team's effect on patient care and outcomes, again highlighting a physician's charge to prioritize patient interests.[7]

One can argue, however, that a team culture that upholds the core values of honesty and commitment to continuous improvement can only truly exist if those values are fully realized with respect to each individual team member. In practical terms, upholding these core values means that team leaders must respect and validate some team members' frustration with low wages and with working conditions that might differ from physicians'. To build trust within the team—and certainly to build commitment to continuous improvement—the most powerful team member—in this case, the physician team leader—must advocate on behalf of those colleagues who have legitimate concerns but no way of effecting meaningful change within the institution.

It's not just team leaders who have a responsibility to create better conditions of practice. Opinion 10.8 outlines guidance for physicians who hold leadership roles in the institution itself. These physicians have a responsibility to "advocate for the resources and support health care teams need to collaborate effectively in providing high-quality care for the patients they serve, including education about the principles of effective teamwork and training to build teamwork skills" and to "encourage their institutions to identify and constructively address barriers to effective collaboration."[7] Addressing legitimate concerns about less powerful colleagues' working conditions and motivating appropriate change certainly falls within this role.

Physicians in leadership positions can use the guidance in Opinion 8.5, "Disparities in Health Care," as a starting point. The opinion states that "stereotypes, prejudice, or bias based on gender expectations and other arbitrary evaluations of any individual can manifest in a variety of subtle ways" and that one way physicians can fulfill their professional obligation to address inequity is to "examine their own practices to ensure that inappropriate considerations … do not affect clinical judgment."[8]

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