

REPORT 01 OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS (I-25)
Amendment to Opinion 1.1.1 “Patient-Physician Relationships”

EXECUTIVE SUMMARY

The Council on Ethical and Judicial Affairs (CEJA) believes that the *AMA Code of Medical Ethics* and the profession would be well served by amending guidance to provide a more robust discussion of the nature of patient-physician relationships and physicians’ associated ethical obligations. Indeed, the practice of medicine has changed in ways that demand a thorough review and potential reconceptualization of the obligations of both individual physicians and the profession as a whole. Ultimately, Opinion 1.1.1 “Patient-Physician Relationships” must move beyond the current language that focuses on when a patient-physician relationship begins in order to more fully address how to ethically and justly sustain the relationship. Furthermore, knowing that the practice of medicine will continue to change and that as a result, so too will patient-physician relationships, the *Code* needs to clearly acknowledge that patient-physician relationships are inherently dynamic, contextual, and will continue to evolve. In light of these considerations, CEJA recommends amending Opinion 1.1.1.

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS

CEJA Report 01-I-25*

Subject: Amendment to Opinion 1.1.1 “Patient-Physician Relationships”

Presented by: Rebecca Brendel, MD, Chair

Referred to: Reference Committee on Ethics and Bylaws

1 The Council on Ethical and Judicial Affairs (CEJA) believes that the AMA *Code of Medical Ethics*
2 and the profession would be well served by amending guidance to provide a more robust discussion
3 of the nature of patient-physician relationships and physicians’ associated ethical obligations.
4 Indeed, the practice of medicine has changed in ways that demand a thorough review and potential
5 reconceptualization of the obligations of both individual physicians and the profession as a whole.

6
7 At the 2025 Annual Meeting, testimony was heard that CEJA Report 06-A-25, “Amendment to
8 Opinion 1.1.1 ‘Patient-Physician Relationships,’” does not address “political and administrative
9 influence” on the patient-physician relationship, and the report was referred back to CEJA.

10
11 In light of these considerations, CEJA has amended the body of the report and the
12 recommendations to better reflect the reality of these external influences. As the first opinion of the
13 *Code*, Opinion 1.1.1 is the foundation that supports all other *Code* opinions, many of which also
14 address the important issues raised by the House. As the foundational opinion, Opinion 1.1.1 ought
15 not be exhaustive and is not designed to address all of the important issues in the opinions that
16 ultimately rely upon it.

17 BACKGROUND

18 *Relevant House Policies*

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20
21
22 Several House policies reference the importance of the patient-physician relationship. Though not
23 an exhaustive list, the following policies capture the spirit of the patient-physician relationship
24 expressed within AMA House policy: [H-165.837](#) “Protecting the Patient-Physician Relationship”,
25 H-225.950 “AMA Principles for Physician Employment”, and [H-275.937](#) “Patient/Physician
26 Relationship and Medical Licensing Boards”.¹⁻³ The patient-physician relationship as expressed by
27 these policies is understood to be fundamental and paramount to the practice of medicine. This
28 relationship is understood to carry certain obligations for physicians, including the duty to be
29 patient advocates, to prioritize patient care, and be transparent regarding cost-sharing
30 arrangements. Other considerations, including personal financial concerns, are to be secondary to
31 the relationship. Furthermore, this relationship is not perceived as purely contractual, as
32 termination of employment does not necessarily end the relationship between a physician and
33 persons under their care ([H-225.950](#)).

* Reports of the Council on Ethical and Judicial Affairs are assigned to the Reference Committee on Ethics and Bylaws. They may be adopted, not adopted, or referred. A report may not be amended, except to clarify the meaning of the report and only with the concurrence of the Council.

1 *Relevant Code Provisions*

2
3 Within the AMA *Code of Medical Ethics*, the patient-physician relationship is understood as:
4 “fundamentally a moral activity that arises from the imperative to care for patients and to alleviate
5 suffering[... that is] based on trust” (Opinion 1.1.1).⁴ This relationship is primarily represented as
6 emerging from a physician’s fiduciary duty to patients, in which both parties enter into this
7 fiduciary relationship via a consensual agreement. Though not an exhaustive list, the following
8 opinions capture the spirit of the patient-physician relationship expressed within the *Code*: [Opinion](#)
9 [1.1.1](#) “Patient-Physician Relationships”, [Opinion 1.1.3](#) “Patient Rights”, [Opinion 1.1.5](#)
10 “Terminating a Patient-Physician Relationship”, [Opinion 1.1.6](#) “Quality”, [Opinion 1.1.7](#) “Physician
11 Exercise of Conscience”, [Opinion 8.6](#) “Promoting Patient Safety”.⁴⁻⁹ These opinions demonstrate
12 that the patient-physician relationship entails fiduciary responsibility, mutual respect, support for
13 the continuity of care, open communication, quality care, and trust.

14
15 In addition, the *Code* offers several opinions that highlight the importance of minimizing outside
16 influence on the patient-physician relationship, such as political or administrative pressures that
17 might negatively impact the relationship. [Opinion 3.1.1](#) “Privacy in Health Care”¹⁰ and [Opinion](#)
18 [3.2.1](#) “Confidentiality”¹¹ underscore the importance of respecting patients’ privacy and
19 confidentiality in all clinical settings and the fundamental importance of doing so to maintain trust
20 in the patient-physician relationship. Similarly, [Opinion 11.1.1](#) “Defining Basic Health Care” states
21 that physicians, both individually and collectively, share an obligation to “advocate for fair,
22 informed decision making about basic health care that[...] [c]onsiders best available scientific data
23 [...] [and] seeks to improve health outcomes to the greatest extent possible”—focusing on the
24 importance of science-based medicine and equity-focused policies regardless of political or
25 administrative pressures to the contrary¹².

26
27 [Opinion 11.2.1](#) “Professionalism in Health Care Systems” notes that models for financing and
28 organizing the delivery of health care services can “pose ethical challenges for physicians that
29 could undermine the trust essential to patient-physician relationships” and acknowledges,
30 “[f]ormularies, clinical practice guidelines, decision support tools [...], and other mechanisms
31 intended to influence decision making, may impinge on physicians’ exercise of professional
32 judgment and ability to advocate effectively for their patients, depending on how they are designed
33 and implemented.”¹³ To support physicians in upholding their ethical obligations, the Opinion
34 states that all such tools should be designed in keeping with science-based medical practices and
35 implemented fairly. This focus on equity is also supported by [Opinion 11.2.7](#) “Responsibilities to
36 Promote Equitable Care”.¹⁴ Lastly, [Opinion 11.2.2](#) “Conflicts of Interest in Patient Care” states,
37 “[t]he primary objective of the medical profession is to render service to humanity; reward or
38 financial gain is a subordinate consideration. Under no circumstances may physicians place their
39 own financial interests above the welfare of their patients.”¹⁵ The Opinion concludes, “[w]here the
40 economic interests of the hospital, health care organization, or other entity are in conflict with
41 patient welfare, patient welfare takes priority.”¹⁵ These opinions emphasize the importance that
42 physicians be allowed to practice science-based medicine grounded in medical ethics without
43 undue pressure from outside influences, including political or administrative pressures that might in
44 any way prevent physicians from upholding their professional and ethical commitments.
45 Regardless of external influences, and often in spite of them, physicians have an ethical duty to
46 support the patient-physician relationship to the best of their ability.

47
48 ETHICAL ISSUE

49
50 Current guidance in Opinion 1.1.1 “Patient-Physician Relationships” focuses heavily on legal
51 considerations about when a relationship is established and has little purchase on the ethical

1 concerns raised by extensive changes to the practice of medicine that have recently occurred.
2 Among these changes are the continuing development of technology (such as augmented
3 intelligence), the use of team-based care, the rising number of employed physicians (as contrasted
4 with those in private practice), interference in the patient-physician relationship by third parties
5 (such as health care administrators, insurers or government), and the recognition that physicians
6 have an obligation to advocate for changes to institutions, policies, and practices in order to
7 improve patient care and promote health care justice.

8
9 A major change to the patient-physician relationship over the past few decades has been an
10 increased recognition of the importance of patient autonomy. Ironically, however, this move away
11 from paternalism towards patient autonomy in the setting of the patient-physician relationship has
12 taken place while medicine has come to be dominated by large institutions, financial concerns such
13 as cost-containment, changes in financing designed to influence patient and physician behavior,
14 commercialization, an increasing reliance on markets, and other pressures that have had a de-
15 professionalizing effect on physicians. These changes have led in turn to a loss of autonomy for
16 both physicians and patients. Even as the discretionary space of physicians has shrunk, their
17 responsibilities have expanded. Physicians are now called to engage in cultural competency and
18 humility, trauma-informed approaches to care, and to recognize past harms and historical contexts
19 of patient populations. They are called upon to be the mechanism by which medical inflation will
20 be controlled. They are called upon to advocate not just only for their own individual patients
21 within systems of care but to advocate for changes in the social systems that determine health care
22 needs and distribute illness, injury, and disability unjustly.

23
24 Recognizing that each patient brings different experiences to the relationship is now seen as a
25 crucial part of establishing trust within a patient-physician relationship. The question that arises,
26 however, is how is that trust to be earned within systems that often appear untrustworthy and
27 designed to frustrate the commitment of physicians to act for the good of their patients?
28

29 ETHICAL ANALYSIS

30
31 The patient-physician relationship is foundational for medical ethics. It is characterized by the
32 nature of illness, the need for healing, and a commitment to help, culminating in a decision to take
33 action directed toward healing and the alleviation of suffering caused by disease, injury, or
34 disability. This relationship is inherently unequal. The patient is unavoidably in a position of
35 vulnerability and dependency, while the physician holds the knowledge and the resources that the
36 patient needs.¹⁶ The sick, injured, and disabled therefore have little choice but to trust that their
37 physicians will use the power of medicine for their good as individual patients. That trust is
38 established by the physician's act of profession—the commitment, generally undertaken through an
39 oath, to be worthy of patients' trust—and the patient's agreement to cooperative collaboration.
40

41 The heart of professionalism is thus the public commitment of physicians to use their medical
42 knowledge, skills, and judgment for the good of their patients. Moreover, since patients are first
43 and foremost persons, true healing can only take place when the uniqueness and personhood of
44 patients are taken into account, incorporating their biological particularities, beliefs, relationships,
45 emotions, values, and goals into medical decisions. This requires a mutually respectful, trusting
46 collaboration aimed at serving the patient's good. For patients, this entails an obligation to seek
47 care and be as candid as possible with their physicians.
48

49 All medical actions are oriented towards the ethical centrality of the patient-physician relationship.
50 While the paradigmatic instance of this dynamic is serious illness, or injury, the care of patients
51 with chronic conditions also requires a sustained, trusting relationship. Palliation, too, aims at the

1 relief of medical suffering and provides healing in a holistic sense even when cure is not possible.
2 Prevention is also oriented towards the good of individual patients and requires trust that
3 interventions are appropriate for that aim. Public health efforts provide the common resources
4 necessary to promote healing and prevent illness, injury, and disability, and thus unite societal
5 commitments to justice and prevention of harm with physicians' duties of beneficence,
6 nonmaleficence, and respect for persons.

7
8 This understanding of the patient-physician relationship makes medicine an inherently moral
9 enterprise, qualitatively different from the commercial transactions of providers and consumers.
10 The patient-physician relationship itself is part of the healing process and not a commodity or
11 product. Even economists recognize that the demand for health care is substantially inelastic and
12 nonfungible, placing it outside the assumptions of normative market economics. Medical
13 knowledge is not property that physicians own. It is a social good built up by the work of
14 generations of physicians, scientists, and researchers and made possible by the generosity of
15 generations of patients who have contributed to the advancement of medical progress (and who, it
16 is acknowledged, have not always consented to such participation).

17
18 Medicine does not exist in a vacuum. Natural, historical, socioeconomic, and political
19 circumstances always condition the patient-physician relationship. Physicians, for instance, do not
20 always live up to the ideals of the profession. Structural social inequities result in unequal access to
21 health care. While the patient-physician relationship itself is not a market commodity, markets
22 provide many of the goods and services that physicians rely on to care for patients. Unfortunately,
23 this also means that these goods and services are subject to the vicissitudes and inequities inherent
24 to market systems, sexism, racism, and other unjust forms of discrimination.

25
26 Political decisions, for good or for ill, can also have a tremendous impact on care, affecting the
27 distribution of physicians, the services they can provide for patients, the conditions under which
28 physicians work, and the tenor of the patient-physician relationship. Therefore, if the good of the
29 patient is the central moral focus of medicine, a commitment to justice will be required to ensure
30 the integrity of the patient-physician relationship and to make the services of physicians available
31 to all who stand in need of their care. In a pluralistic, liberal democracy, this requires, in turn, that
32 professions be granted a relatively independent status outside other social institutions such as the
33 market and the government. Too much encroachment by the market or the government into the
34 legitimate authority of the medical profession ultimately undermines the central moral focus of
35 medicine: the patient-physician relationship. Likewise, without the proper degree of self-regulation
36 and respect for other social institutions, the medical profession itself can lose track of its own moral
37 center. The good of the patient ought never to be made subservient to the political or financial ends
38 of physicians, governments, or markets. Determining what the good of the patient is requires that
39 physicians have the freedom and flexibility to adopt a patient-centered approach to care that allows
40 for patients to feel heard and respected.

41
42 As the profession of medicine continues to change, there are concerns about how these changes
43 impact patient-physician relationships and thus the relevance of the patient-physician relationship
44 itself. However, despite the evolving landscape of the medical profession, the patient-physician
45 relationship remains vital to the practice of medicine and to medical ethics. Regardless of changes
46 to their roles that physicians face, clinical encounters will always be subject to the professional and
47 ethical obligations that emerge from patient-physician relationships.

48
49 When we examine the patient-physician relationship, what we are really after is the source of the
50 obligations that ground medical ethics. While medicine has always been practiced under non-ideal
51 circumstances that can make it difficult to carry out these obligations to a maximal extent, we

1 recognize that current circumstances are making it more difficult than ever. Moreover, we
2 recognize that a patient-physician relationship may arise in a variety of contexts, and that these
3 may not always be geared towards benefiting the patient, the physician, or both. The goal of this
4 report, however, is to outline the core aspects of ethical and just patient-physician relationships and
5 articulate gaps in the current *Code Opinion 1.1.1*. in order to better support patients and physicians
6 as the medical profession and health care ecosystems continue to evolve.

7 8 *Trust and the Patient-Physician Relationship*

9
10 The pressures of increasing de-professionalization and de-personalization in the healthcare
11 environment have sometimes obscured or even seemed to denigrate the value of the patient-
12 physician relationship. New ethical questions have arisen as systems of care have changed in ways
13 that have made it more difficult for physicians to fulfil their duties that arise from a recognition that
14 this relationship is central to the meaning and value of the profession. While the patient-physician
15 relationship has responded and evolved in light of these challenges and in the face of other
16 technological, economic, and sociocultural changes, there can be no doubt that patients' trust in
17 medicine has declined. Nonetheless, there is also a renewed interest in the relational aspect of the
18 patient-physician relationship and new attempts to build the trust that sustains it.

19
20 Trust is in many ways the cornerstone of any interpersonal relationship. Social psychologists who
21 study trust have noted that the development of dyadic trust is a process that involves commitment,
22 cooperation, and the building of confidence in benevolent values, motives, goals, and intentions.¹⁷
23 Trust—and distrust—may be enacted in the immediate but is also built over time. Interpersonal
24 trust is also impacted by (and in turn impacts) social trust, as social trust influences the
25 development of interpersonal trust which then also impacts trust in the institutions in which
26 interpersonal interactions take place.¹⁸

27
28 To protect the patient-physician relationship, then, a central goal of the medical profession should
29 be to foster trust in health care, which has been in sharp decline for the past half century.¹⁹ One of
30 the primary means to engender trust is through good communication. Research has shown that
31 aspects of physician communication can impact patient outcomes (such as medication compliance)
32 and patient satisfaction (which is associated with greater continuity of care), and that patient-
33 centered approaches to care, which consider the patient's perspective on equal ground with the
34 physician's clinical diagnosis, enhance communication and the patient-physician relationship.²⁰

35 36 *Fostering Trust to Support the Patient-Physician Relationship*

37
38 Research on physician communication practices have found at least five broad communication
39 categories including: information giving, information seeking (questioning), partnership building,
40 rapport-building behaviors (both verbal and nonverbal behaviors that explicitly convey emotional
41 content), and socioemotional behaviors.²¹ How patients and physicians view these aspects of
42 communication, and the patient-physician relationship in general, are not always the same,
43 however. In one study comparing physician and patient evaluations of the relationship, researchers
44 found that while physicians identified their technical expertise and knowledge as vital for
45 establishing trust in the relationship, emphasizing the importance of competence, devotion,
46 serviceability, and reliability, patients stressed the importance of interpersonal skills as more
47 important, such as caring, appreciation, and empathy.²² Recognizing this difference in perceptions
48 is crucial for understanding how trust can be gained or lost, especially considering that researchers
49 found trust to make the largest contribution to patient-physician perceived satisfaction.²²

1 Patient satisfaction is strongly associated with positive physician communication behaviors.
2 Because physicians' communication behaviors vary widely, however, there is significant room here
3 for improving patient-physician relationships. One study found that only 33% of physicians were
4 rated "excellent" on all four communication behaviors analyzed, while 12% were rated either "fair"
5 or "poor" on all four behaviors.²³ Patient-physician communication is one of the strongest factors
6 that impact patient satisfaction and is fundamental to facilitating shared responsibility and trust.²⁴

7
8 Communication is not the only value that engenders and supports trust. Research has found that
9 clinicians whose patients expressed trust in them worked in environments that placed an emphasis
10 on quality, communication, clinical cohesion, and alignment of values between clinicians and
11 organizational leaders.²⁵ Like communication, physician empathy has also been regarded as central
12 to patient-centered care, and research has found that empathy correlates with patient satisfaction,
13 adherence, outcomes, and enablement.²⁶ Other models of trust establish foundational factors that
14 include competency, motive, and transparency.¹⁹

15 16 *The Future of Patient-Physician Relationships*

17
18 When considering the source of the ideal patient-physician relationship, its emergence is
19 simultaneously contractual, dependent on virtues, and relational. All three of these conceptual
20 models rely on trust, and trust in turn is supported by additional values. Interpersonal trust is reliant
21 upon collaboration, respect, empathy, and reciprocity. Contractual trust is reliant upon competency,
22 transparency, aligned motives, and continuity. These values in many ways become ideal virtues
23 within health care that help create trust in the institution of medicine over time, which is crucial for
24 initial clinical encounters as well as for individuals who lack capacity. Regardless of external
25 influences, such as political or administrative pressures, physicians have a responsibility first and
26 foremost to their patients and to supporting the patient-physician relationship. When these
27 influences create conflicting priorities, physicians should ensure that their actions align with their
28 professional and ethical obligations.

29
30 Physicians have an ethical duty to support the patient-physician relationship by upholding the
31 virtues of the profession. This ethical duty is grounded in medical professionalism and the
32 commitment to serve as healers. The relationship that patients and physicians enter into is sustained
33 by trust—in both the profession as whole, as well as in both the patient and the physician who
34 agree to participate in a cooperative and collaborative partnership. This trust gives rise to
35 physicians' ethical responsibility to place patients' welfare above the physician's own self-interest.
36 This partnership is unique in that it is inherently unequal in terms of vulnerability, yet equal in
37 importance with respect to both individuals' contributions to the relationship; similarly, the
38 relationship is not a commodity product, yet it involves interacting with market economics. The
39 patient-physician relationship is contextual—biological, historical, socioeconomic, and political
40 elements will always be relevant—but it is also fundamentally a moral activity.

41
42 Honavar writes, "[the p]atient-physician relationship is a complex psychosocial interplay of
43 vulnerability, trust, and authority in a professional setting".²⁷ Currently, the *Code* primarily speaks
44 to the importance of trust within the patient-physician relationship without acknowledging that the
45 reason trust is crucial is because of the unequal vulnerabilities and authorities at play. The power
46 dynamics of every patient-physician relationship will be different, of course, but it is crucial that
47 the *Code* address such concepts as patient vulnerability, the importance of respect, communication,
48 and competency in establishing trust. Ultimately, Opinion 1.1.1 must move beyond the current
49 language that focuses on when a patient-physician relationship begins in order to more fully
50 address how to ethically and justly sustain the relationship. Furthermore, knowing that the practice
51 of medicine will continue to change and that as a result, so too will patient-physician relationships,

1 the *Code* needs to clearly acknowledge that patient-physician relationships are inherently dynamic,
2 contextual, and will continue to evolve.

3
4 RECOMMENDATION

5
6 Your Council on Ethical and Judicial Affairs recommends that Opinion 1.1.1, “Patient Physician
7 Relationships” be amended by addition and deletion and the remainder of this report be filed.

8
9 The practice of medicine, and its embodiment in the clinical encounter between a patient and a
10 physician, is fundamentally a moral activity that arises from the imperative to care for patients
11 and to alleviate suffering. ~~The relationship between a patient and a physician is based on trust,~~
12 ~~which gives rise to~~ The relationship that emerges between a patient and a physician must be
13 based on trust. The physician’s obligation to be trustworthy entails additional ethical duties
14 such as a commitment to act for the good of patients; to uphold respect for patients as persons;
15 to develop good communication skills; and to be professionally competent. This trust is
16 fostered by physicians’ ethical responsibilityies to place patients’ welfare above the physician’s
17 own self-interest or obligations to others, to use sound medical judgment on patients’ behalf,
18 and to advocate for their patients’ welfare. When external influences negatively impact this
19 trust, or the patient-physician relationship directly, physicians individually and collectively
20 should advocate for changes to ameliorate the situation and promote a more hospitable
21 environment in which patient-physician relationships may flourish.

22
23 A patient-physician relationship ~~exists~~ commences when a physician begins to serve a patient’s
24 medical needs. ~~Generally, the relationship is entered into by mutual consent between physician~~
25 ~~and patient (or surrogate). However, in certain circumstances a limited patient physician~~
26 ~~relationship may be created without the patient’s (or surrogate’s) explicit agreement. Such~~
27 ~~circumstances include:~~ The contexts that may lead to a patient-physician relationship vary: they
28 generally occur as a response to a request by a patient or a patient’s surrogate, but can also
29 include certain contractual, legally mandated, or emergency settings without the explicit
30 request or consent of the patient.

31
32 While the patient-physician relationship may involve one patient and one physician in today’s
33 complex health care system, such relationships often involve multiple members of a care team,
34 patient family members and surrogates. The core values of the patient-physician relationship,
35 however, remain unchanged. How these values are implemented will depend on many factors,
36 including the setting, the needs of the patient, the duration of the relationship, and the training,
37 expertise, and experience of the physician, and will necessarily reflect the myriad ways that
38 patients and physicians interact. While every patient-physician relationship will be different
39 and will change over time, the fundamental importance of establishing and sustaining trust
40 through respect for persons, good communication, and professional competency will always be
41 crucial at every layer, node, and time of the relationship. It is the duty of physicians, therefore,
42 to uphold these values and support patients and the primacy of the patient-physician
43 relationship to the best of their ability in all practice settings and at all times.

44
45 (a) ~~When a physician provides emergency care or provides care at the request of the patient’s~~
46 ~~treating physician. In these circumstances, the patient’s (or surrogate’s) agreement to the~~
47 ~~relationship is implicit.~~

1 ~~(b) When a physician provides medically appropriate care for a prisoner under court order, in~~
2 ~~keeping with ethics guidance on court initiated treatment.~~

3
4 ~~(c) When a physician examines a patient in the context of an independent medical~~
5 ~~examination, in keeping with ethics guidance. In such situations, a limited patient-~~
6 ~~physician relationship exists.~~

7
8 (Modify HOD/CEJA Policy)

Fiscal Note: Minimal

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