

Code of Ethics: Principles for Ethical Leadership

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Abstract

The code of ethics for a professional association incorporates values, principles, and professional standards. A review and comparative analysis of a 1934 pledge and codes of ethics from 1957, 1977, 1988, 1998, 2004, and 2011 for a health information management association was conducted. Highlights of some changes in the healthcare delivery system are identified as a general context for the codes of ethics. The codes of ethics are examined in terms of professional values and changes in the language used to express the principles of the various codes.

Key words: values, ethics, code of ethics, health information management, health information management professional, health information management professional association, ethical decision-making, healthcare system

Introduction

People have been creating medical records since antiquity, as evidenced by the drawings of medical conditions and surgeries in the cave wall paintings created by early humans. In the early days of the United States, Benjamin Franklin created the first patient information register at what is now Pennsylvania Hospital in Philadelphia with the "...patient's name, address, disorder, the dates of admission and discharge with the result on discharge...."¹ The health information system of today is incredibly complex, and a code of ethics is an important resource for the decisions that must be made at work. The principles in a code of ethics can provide invaluable assistance for the ethical health information management (HIM) leader.

Initiation of the Medical Record Professional Association

In 1912, a "Club of Record Clerks" met at Massachusetts General Hospital to study clinical records, and Grace Whiting Myers attended the meetings. In 1913, the American College of Surgeons (ACOS) was founded, and in 1928 the ACOS needed a mechanism to review the surgical work of their fellowship candidates, based on the submission of medical records. "The College thus realized that some method would have to be devised in their standardization program to provide better medical records for use not only by candidates for fellowship, but also for something much more important—for efficient care of the patient in present and future illnesses, for the medicolegal needs of the hospital, physician and the patient and for use in medical research."²

The ACOS sought to properly evaluate the work of the surgical candidates for fellowship; hence the need for standardization in record content was identified.³ The ACOS contacted Grace Whiting Myers, librarian emeritus of Massachusetts General Hospital, and she organized the activities for the conference, which was attended by medical librarians from the United States and Canada. She was appointed as the first president of the Association of Record Librarians of North America (ARLNA).^{4,5} This conference elevated the standards for medical records by addressing the content, availability, and preservation of the medical record.⁶

Professional Values, Ethical Principles, and Ethical Problems

Professional values form the basis for the principles that are included in a code of ethics. Professional values for HIM include the importance of education and technical competency, patient safety, data validity and accuracy, truthfulness, compassion, and dedication to providing quality services in professional roles. Decision-making criteria for work decisions can include technological feasibility, reasonable cost, legality, available personnel expertise, standards of care, and organizational goals. The

ethical decision is what should be done (the best action), given the competing interests, obligations, and values of others involved in making the decision. This criterion requires the professional to consider values that are beyond the personal and to take into account the values and perspectives of others who are involved.

The core ethical principles of beneficence (do good), nonmaleficence (do not harm), autonomy (control by the individual), and justice (fairness) stated by Beauchamp and Childress⁷ are important to a code of ethics. A review of codes of ethics from 1957 to 2004 revealed the following values: providing service to others; protecting information; promoting confidentiality and teaching others of the importance of this principle; preserving and securing health information; promoting the quality and advancement of healthcare; reporting data with integrity and accuracy; promoting interdisciplinary cooperation and collaboration; demonstrating loyalty; complying with laws, regulations, and policies; recognizing the authority and responsibilities of the HIM professional; advocating for needed changes in the health information system; refusing to participate in or to conceal unethical or illegal activities; reporting violations of practice standards to the proper authorities; being honest about credentials, degrees, certifications, and work experiences; bringing honor to self, peers, and the profession; committing to continuing education and lifelong learning; discharging association duties honorably; strengthening professional membership; representing the role of the profession to the public; and promoting and participating in research.⁸ The code of ethics of the American Health Information Management Association (AHIMA) that was passed in 2011 includes these same values.⁹

Importance of a Code of Ethics for the Professional Association

HIM professionals face many ethical problems, including issues related to privacy and confidentiality; compliance, fraud, and abuse; clinical code selection and use; quality review; research and decision support; public health; managed care; clinical care; electronic health information systems, including information security, software development and implementation, data resource management, integrated delivery systems, e-health, information technology, and information exchange; management of sensitive information (genetic, adoption, and behavioral health); management; entrepreneurship; vendor management; and advocacy.¹⁰ The problems that emerge can be solved using technical or administrative standards or criteria as described above; however, the decisions can be strengthened for the professional if a code of ethics is used.

HIM professionals cannot wait for the law, policies and procedures, and other administrative systems to guide their actions because problems often arise and decisions must be made prior to the ability of these systems to offer guidance. For example, genetic discrimination and medical identity theft had to be dealt with far in advance of legislation or policies and procedures to guide actions. A code of ethics can provide immediate guidance on what should be done.

Following the creation of the professional association in 1928, an ethical pledge was written in 1934 to guide professional behaviors. The ethical pledge was written and presented by Grace Whiting Myers at the first annual professional convention.¹¹ This pledge was expanded in 1935 and used by members of the professional association until 1957, at which time the first code of ethics was approved.¹² Five codes of ethics were subsequently adopted by the association, with the most recent code of ethics approved in 2011.¹³⁻¹⁷ The health information professional has had a stable and consistent connection with the importance of values and ethical decision-making throughout this timeframe. The codes of ethics allowed professionals to examine the complexities of the world of work and to obtain guidance for ethical decision-making.

Development of a Code of Ethics for the Professional Association

A profession develops in the context of the world, not in an isolated silo. A professional HIM code of ethics is shaped by the context of the times, changes in the healthcare system, and the issues faced by the profession and the public at large. See [Table 2](#) for some of the changes in the healthcare system at the time that the various codes of ethics were passed. The association changed its name several times over the years: the Association of Record Librarians of North America (ARLNA) 1928; American Association of Medical Records Librarians (AAMRL) 1938; American Medical Record Association (AMRA) 1970; American Health Information Management Association (AHIMA) 1991.

Table 2
Historical Environment of the Codes of Ethics

A code of ethics is developed within the context of the healthcare environment and, at times, world events. This review is not intended to be a complete study of history, and the facts related to the year of passage of a code of ethics are cited only as a point of reference. The reader is encouraged to contemplate these events and consider what bearing the events may have had on each code of ethics.

Year	Environment and Events
1930s	The 1930s was marked by the Depression, unemployment, and a lack of healthcare coverage. This time period ushered in the beginning of insurance, marked by the beginning of private (prepaid hospital) insurance by Blue Cross. The Social Security Act of 1935 was passed without a health insurance component.
1950s–1960s	The healthcare industry advanced with computerization in billing functions and advancement in health technology such as the introduction of the pacemaker in 1952, the introduction of the heart-lung machine in 1953, and the first successful kidney transplant in 1954. ^a Ultrasound scanning was pioneered in Scotland; the Asian flu pandemic caused more than 1 million deaths worldwide. ^b The first nuclear reactor plant opened in Pennsylvania, which exposed people to the risk of radiation and made people vulnerable to manufactured forces beyond their control, in addition to the forces of nature. Individuals could control purchases, such as a home, food, or gas, but they could not control the forces of politics, nature, or technology. As we became more global and aware of what was happening to others on an immediate basis because of communication technologies, the pressure increased to protect the potentially vulnerable individual in the health information system and the information collected, used, and disseminated.
1970s	Cost containment in healthcare became a focus. The Health Maintenance Organization (HMO) Act of 1973 was a federal law passed to encourage employers to develop and seek HMO initiatives. The first test-tube baby was born in England. Sweden became the first nation to ban aerosol sprays that were thought to damage earth's protective ozone layer. Britain launched the Motability program to provide cars for disabled people. ^c
1980s	The 1980s offered a time of regulation and deregulation as the federal government increased regulation on health reimbursement. The implementation of diagnosis related groups (DRGs) in 1983 changed the nature and importance of the medical record professional's role in a highly regulated government environment. The first laser eye surgery was performed in the United States. Crack (a derivative of cocaine) was available to the public. The antidepressant Prozac was introduced and quickly became the market leader for treating depression. Computer viruses started to surface. ^d
1990s	Beginning in 1994, a series of Physicians at Teaching Hospitals (PATH) Audits were conducted by the federal government to investigate improper billing by teaching hospitals and physicians. In December 1995, the University of Pennsylvania settled for 30 million dollars with the Department of Justice for questionable billing practices. Major privacy and security legislation, the Health Insurance Portability and Accountability Act (HIPAA), was enacted in 1996. The Institute of Medicine report <i>To Err is Human: Building a Safer Health System</i> was released in 1999.
2004	In 2003, the government implemented the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA).
2009–2011	In 2009, the Health Information Technology for Economic and Clinical Health (HITECH) Act, part of American Recovery and Reinvestment Act of 2009 (ARRA), included provisions to advance the use of health information technology by including privacy, security, and electronic health record incentives.

^aGarber, K. M. "Eight Decades of Health Care: Hospitals & Health Networks: 80th Anniversary. The 1980s." *Hospitals & Health Networks* 81, no. 7 (2007): 12–15.

^bThe People History. "The Year 1957 from the People History." Available at <http://www.thepeoplehistory.com/1957.html> (accessed March 11, 2012).

^cThe People History. "The Year 1977 from the People History." Available at <http://www.thepeoplehistory.com/1977.html> (accessed March 11, 2012).

^dThe People History. "The Year 1988 from the People History." Available at <http://www.thepeoplehistory.com/1988.html> (accessed March 11, 2012).

1934—The Pledge—Core HIM Values

The Pledge of the American Association of Medical Record Librarians, written in 1934, incorporated values and professional practice standards that carried forward to future codes of ethics. The responsibility to protect privacy was clearly defined in

the 1934 pledge. This pledge was written and read by Grace Whiting Myers at the first annual professional association meeting in Boston as follows:

I pledge myself to give out no information from any clinical record placed in my charge, or from any other source to any person whatsoever, except upon order from the chief executive officer of the institution which I may be serving.¹⁸

The pledge identified the responsibility of the medical record professional to protect privacy and to release information only if authorized. The pledge was expanded in 1935 when the association's emblem was approved, and standards for ethical conduct were incorporated.¹⁹ See [Table 1](#) for the full pledge. Subsequent codes of ethics built on the core values and principles of this pledge.

Table 1

1934 Pledge of the American Association of Medical Record Librarians

The responsibility to protect privacy was clearly defined in the 1934 Pledge of the American Association of Medical Record Librarians. This pledge was written and read by Grace Whiting Myers at the first annual professional association meeting in Boston as follows:
<i>I pledge myself to give out no information from any clinical record placed in my charge, or from any other source to any person whatsoever, except upon order from the chief executive officer of the institution which I may be serving.</i>
The pledge was expanded in 1935 as follows:
<i>RECOGNIZING that the AMERICAN ASSOCIATION OF MEDICAL RECORD LIBRARIANS seeks to develop and enforce the highest standards of work among its members, I hereby pledge myself, as a condition of membership, to conduct myself in accordance with all its principles and regulations.</i>
<i>IN PARTICULAR, I pledge myself to pursue the practice of my profession in a spirit of unselfishness, and of loyalty to the Association and to the institution which I am called to serve; to bear always in mind a keen realization of my responsibility; to seek constantly a wider knowledge of my profession through serious study, through instruction by competent approved teachers, throughout interchange of opinion among associates, and by attendance at meetings of this and of allied associations; to regard scrupulously the interests and rights of my fellow-members, and to seek counsel among them when in doubt of my own judgment.</i>
<i>MOREOVER, I pledge myself to give out no information concerning a patient from any clinical record placed in my charge, or from any other source, to any person whatsoever, except upon order from the chief executive officer of the institution which I may be serving; and to avoid all commercialization of my work.</i>
<i>FINALLY, I pledge myself to co-operate in advancing and extending by every lawful means within my power, the influence of the AMERICAN ASSOCIATION OF MEDICAL RECORD LIBRARIANS.</i>
<i>Sources: Huffman, E. K. <i>Manual for Medical Record Librarians</i>. 6th ed. Chicago: Physician's Record Company, 1972, p. 135; Harman, L. B., and V. L. Mullen. "Professional Values and the Code of Ethics." In L. B. Harman (Editor), <i>Ethical Challenges in the Management of Health Information</i>. 2nd ed. Sudbury, MA: Jones and Bartlett, 2006, p. 10.</i>

1957—First Code of Ethics

The pledge was adequate for guiding professional behaviors until 1957, at which time the professional association passed the first code of ethics.²⁰ This code of ethics engaged the professional values and ethical principles of service, honor, and the advancement of medical record science, among other values such as placing service before material gain; bringing honor to self, associates, and the medical record profession; preserving and protecting medical records; providing service; honoring the welfare of patients; preserving and protecting privacy and confidential information; following laws and regulations; serving the employer loyally; refusing to participate in or conceal unethical practices; reporting violations to proper authorities; preserving the confidential nature of committees; accepting customary and lawful fees; staying within the scope of responsibilities; advancing medical record science and maintaining continuing education; strengthening professional manpower; honoring association responsibilities; and stating degrees, experience, and credentials accurately. The code of ethics also recognized the importance of the HIM professional's responsibility to support medical research by "assisting the doctor in the immediate care of the patient and assisting him in the future care of the patient through medical research."²¹

Some highlights of this code of ethics include the following principles:

- “Principle #1: Place service before material gain, the honor of the profession before personal advantage, the health and welfare of patients above all personal and financial interests, and conduct himself in the practice of this profession so as to bring honor to himself, his associates, and to the medical record profession.”²² These themes reoccur in all subsequent codes of ethics.
- “Principle #3: Serve his employer loyally, honorably discharging the duties and responsibilities entrusted to him...”²³ What did *service* mean in 1957? Operations management was important following World War II. At that time, organizations were concerned with time, production, and automation. The hospital purchased the medical record librarian’s *time*. In return, the librarian should be “scrupulously honest” in dedicating time to the employer. For example, a 1956 discussion of ethics for medical record librarians notes: “Too long a coffee break and too much irrelevant conversation take away the dignity of our work, as well as being dishonest.”²⁴

1977—*The Second Code of Ethics*

The 1977 code of ethics highlighted service to the professional organization by placing this principle first in the code. An introduction that described the role of the HIM practitioner and the professional association was added. The individual was evaluated in the context of the larger community and network of relationships. The code of ethics dealt with association responsibilities (the larger community within which HIM professionals functioned) and moved beyond the focus on the patient to others in the world of work and the professional communities. In addition to the resequencing of the principle statements to put service to the association first, two additional principles related to the association were added. The code also added a principle related to the protection of secondary records, the right to privacy of medical *and* social information, and the reporting of breaches to a professional ethics committee. This code of ethics supported promoting the quality of healthcare, advancing medical care, and respecting all healthcare professionals.²⁵

1988—*The Third Code of Ethics*

The 1988 code of ethics eliminated the description of the HIM practitioner that was previously included; added the phrase “The Medical Record Professional” at the beginning of each principle; shortened the description of the professional association in the introduction; deleted language related to service, honor, and welfare of patients and inserted the phrases “demonstrates behavior that reflects integrity, objectivity and trust” and “respects dignity of each human being”; added “illegal” and “incompetent” to the language related to the refusal to participate in or conceal unethical actions; deleted the language relating to the reporting of inappropriate behaviors; and changed the language related to the need to “encourage” appropriate use of information and “advocate” for policies and procedures. This code of ethics reinforced the integrity and trustworthiness of the HIM professional.²⁶

1998—*The Fourth Code of Ethics*

In 1991, the association changed its name from the American Medical Record Association (AMRA) to the American Health Information Management Association (AHIMA).

The 1998 code of ethics “advocated patient privacy rights and confidentiality of health information,”²⁷ as noted in earlier codes and the 1934 pledge. The 1998 code of ethics appropriately emphasized the dignity of all individuals. It added AHIMA’s mission, guiding principles, and values to the introduction and added a statement indicating that the code of ethics was binding for all who hold an AHIMA credential. The code used language referring to quality several times in the guiding principles. The use of this word signified the tremendous tensions experienced by the HIM professional when performing work responsibilities, such as the tension between quality documentation, accurate coding/billing, and quality care. The language and sequence included the following items:

- Respect the rights and dignity of all individuals;
- Comply with all laws, regulations, and standards governing the practice of health information management;
- Strive for professional excellence through self-assessment and continuing education;
- Truthfully and accurately represent professional credentials, education, and experience;
- Adhere to the vision, mission, and values of the association;
- Promote and protect the confidentiality and security of health records and health information;
- Strive to provide accurate and timely information;

- Promote high standards for health information management practice, education, and research; and
- Act with integrity and avoid conflicts of interest in the performance of professional and AHIMA responsibilities.²⁸

In 2000, the certification titles changed from registered record administrator (RRA) to registered health information administrator (RHIA) and from accredited record technician (ART) to registered health information technician (RHIT). These changes, which were consistent with the 1991 association name change, were a sign of the times. The use of electronic rather than paper health records increased, and the roles and responsibilities of the HIM professional expanded.²⁹

2004—The Fifth Code of Ethics

The 2004 code of ethics included a preamble that highlighted the ethical obligations of the HIM professional, the importance of professional values, the purposes of the code of ethics, and how the code should be used by HIM professionals and others who use health information on behalf of patients. Examples of ethical and unethical behavior were included to guide ethical decision-making. Forty-two guiding statements were associated with the principles. For example, for Principle II (“Put service and the health and welfare of persons before self-interest and conduct themselves in the practice of the profession so as to bring honor to themselves, their peers, and to the health information management profession”), the code included that HIM professionals shall “act with integrity, behave in a trustworthy manner, elevate service to others above self-interest, and promote high standards of practice in every setting” and shall not “take unfair advantage of any professional relationship or exploit others to further their personal, religious, political, or business interests.”³⁰ The preamble, values, and statements related to ethical behaviors attested to the power of the individual to make a difference. The HIM professional should put others first and make a difference in the quality of the services that are provided.

The 1998 code of ethics included language that supported “striving” to provide professional excellence and accurate and timely information and had eliminated the principle related to refusing to participate in or conceal unethical practices and procedures. The 2004 code eliminated the verb “strive” and reintroduced the principle related to the refusal to participate in or conceal unethical practices.

2011—The Sixth Code of Ethics

The 2011 code of ethics followed the format of the 2004 code and incorporated language to reflect changes in technology, the healthcare system, and association management, and it “provides enhanced steps for reporting individual, unprofessional actions.”³¹ The full code of ethics is available at www.ahima.org/about/ethicscode.aspx. The code included the values of quality, integrity, respect, and leadership. This code strengthened guidelines to prevent inappropriate use of electronic and written information and addressed concerns related to the Health Insurance Portability and Accountability Act (HIPAA). It included a reference to the professional ethics committee’s policies and procedures to help navigate issues that may include potential ethics violations, and it encouraged all members to actively recruit and mentor students, peers, and colleagues. The code established guidelines for fair work practices and encouraged improvement of colleagues’ skills and knowledge. It strengthened guidelines to support operations within the professional association and continuing education efforts. The code also dealt with formalizing processes given the growth of the profession and the complexity of electronic health information systems and the external systems that influence these systems.

Discussion

Grace Whiting Myers and the other visionary leaders who launched the HIM professional association recognized a core ethical principle of the profession—to protect patient information—and the need to demonstrate “behavior that reflects integrity, supports objectivity, and fosters trust in professional activities.”³² In writing the first pledge, they recognized the importance of competency, integrity, truthfulness, trust, compassion, dedication to others, and courage in carrying out the responsibilities of a HIM professional.

Ethical principles such as beneficence, autonomy, justice, and fidelity will be challenged as electronic health information systems evolve. Although electronic health records (EHRs) will be beneficial, their universal adoption will not come without conflict. Autonomy must be addressed in bills of patient rights. Patients must have the right to review and make corrections in their electronic record, and this right must be honored especially as states and organizations develop health information exchanges (HIEs). The principle of justice can be violated in use of public data—data from the EHR must be presented and

used in ways that promote justice. Justice can also be demonstrated by allowing access to health information for all individuals and reducing disparities. Finally, breaches in the electronic health record can destroy the principle of fidelity.³³

Moral intelligence is also important for understanding the complexity of the issues that are faced.³⁴ There is an increased understanding that technological systems require moral guidance in design and application. The focus on technology and human relationships increases ethical imperatives because what is done, how it is done, and what the intended (and sometimes unintended) outcomes are must be carefully examined.³⁵

The dilemmas faced today require interdisciplinary ethical collaboration with clinicians, administrators, ethicists, lawyers, policy makers, accreditation agencies, patients, and patients' advocates. There is no linear path that can predict the requirements of each new code of ethics. It is important for HIM professionals who work on each code of ethics to be aware of the changes in the political, social, and healthcare environment that may need to be addressed in the principles and guidelines for action.

The 1934 pledge and the six codes of ethics for the HIM professional association have provided guidance for ethical leadership across a continuum of time, roles, and responsibilities. These codes are an invaluable resource to assist the professional faced with complex challenges at work. HIM professionals can use the code of ethics to provide guidance for ethical decision-making. "As the founders of AHIMA recognized, the profession requires information management expertise, courage, and ethics—today more than ever. Bioethical decisions always require action. Ethical actions at work always require courage."³⁶ The founders of the association recognized the importance of balancing the protection of privacy and the need to access health information.

It would be feasible for the association to review and approve a new code of ethics in 2028, the 100th anniversary of the founding of the association. The HIM association was launched by medical librarians (now called medical science librarians) who recognized the importance of the information maintained in medical records. Even today, HIM professionals have much in common with medical science librarians: A 2003 analysis of accreditation standards for baccalaureate and master's programs in HIM and master's programs in medical library and information science programs identified shared curriculum requirements across the two disciplines, including information technology; healthcare information systems; healthcare information requirements and standards; health data content and structures; the healthcare delivery system; organization and management; research, analysis, and interpretation; and health information services management. It is therefore conceivable that the 2028 code of ethics could be written in collaboration with medical science librarians.

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Notes

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² Ibid., p. 21.

³ Huffman, E. K. *Medical Record Management*. 7th ed. Berwyn, IL: Physician's Record Company, 1981, p. 22.

⁴ AHIMA. "[Celebrating 75 Years of Excellence: An AHIMA Timeline](#)." (accessed March 11, 2012).

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