This paper reports on an April 2000 conference in Cambridge, MA, to discuss a “Shared Statement of Ethical Principles for Everyone in Health Care.” The “Statement” was actually a series of six propositions, each with two to five subpropositions designed to establish a shared ethical code “…that might bring all stakeholders in health care into a more consistent moral framework.”

The background of the conference was set out in a December 1997 editorial in the *British Medical Journal (BMJ)* entitled “An ethical code for everybody in health care.” It was the premise of the editorial that care of patients was now influenced by so many complex interactions that an ethical code generated by a single profession was no longer “a sufficient moral compass.”

The authors of the 1997 *BMJ* editorial included three representatives from the Boston complex of health care institutions. They were Donald Berwick, MD, President, Institute for Health Care Improvement; Howard Hiatt, MD, Professor of Medicine, Harvard Medical School; and Ms Penny Janeway, Executive Director, Initiatives for Children, American Academy of Arts and Science in Cambridge, MA. The fourth author, from London, England, was Richard Smith, Editor, *BMJ*.

The editorialists asserted that no single profession could credibly declare that its own ethical code was adequate. As a result, they had embarked on the search for “an ethical code to cover everybody involved in health care.”

After presenting a series of ethical dilemmas involving individual and organizational case studies from Great Britain and the United States, the editorialists cited a number of current initiatives to address these questions from the standpoint of organizations such as the American Hospital Association, the American Medical Association, the British Medical Association, and a group of clinicians in Massachusetts. They judged all such efforts inadequate because they did not bind and guide equally such diverse stakeholders as “…doctors, nurses, other health professionals, healthcare managers and executives, regulators of care, and private and public players”.

To begin the process of creating a more ecumenical code of ethics, they had earlier written letters to more than 100 health care leaders and academicians in a dozen countries. Replies indicated the existence of many related ethical initiatives, but nearly all involved professions and disciplines rather than the system of care as a whole.
Acting on many encouraging responses, and with foundation support, a group of 15 leaders with diverse backgrounds assembled in February 1998 to survey the need and write an initial draft code of ethics. This “Tavistock Group” (so called because of its initial meeting at the British Medical Association’s House in London’s Tavistock Square) included ethicists, members from medicine and nursing, health care executives, and a jurist, an economist, and a philosopher. They soon decided that a “code of ethics” was too restrictive to fit the prevailing circumstances both within and among nations. Instead, they constructed a draft to embody generic statements of ethical principles that might be helpful throughout the entire world of health care settings.

Attached to the initial progress report of the Tavistock Group was “A Shared Statement of Ethical Principles for those who Shape and Give Health Care.” In its original form, the statement contained five principles and interpretative statements, but before the April 2000 conference in Cambridge, the conveners added a sixth principle, well recognized by generations of health care ethicists: “Do no harm.”

A draft of the six major principles that should govern health care was placed on the agenda at the April 2000 conference as follows:

1. Health care is a human right.
2. The care of the individual is at the centre of health care, but the whole system needs to work to improve the health of populations.
3. The health care system must treat illness, alleviate suffering and disability, and promote health.
4. Co-operation with each other, those served, and those in other sectors are essential for all who work in health care.
5. All who provide health care must work to improve it.
6. Do no harm.

Each principle was presented by a main speaker, followed by a designated commentator before open discussion from an audience of more than 100 participants. On the second day of the conference, small group discussions allowed more intensive exchanges between participants, and the results of these group discussions were reported to the assembly by the moderators.

Among the participants were representatives of several health care institutions that had undertaken to test under practical conditions the use of the six principles of the draft statement. They presented reports of their experiences under what was known as a “fast track” testing, while recognizing that the six principles were still subject to modification. These reports elicited spirited discussion of practical issues in implementation.

Two major issues underlay all the discussions. The first concerned construction and phrasing of the six principles that should govern health care; the second, if the principles were drawn up satisfactorily, how they would be widely distributed and implemented to guide everyone concerned in the provision of health care.

The magnitude of these two issues was well recognized by the Tavistock Group during its early deliberations. To bring the geographic scope of application into a more manageable dimension, the decision was made before the current conference