American College of Physicians Ethics Manual: Excerpts

The Relationship of the Physician to Other Health Professionals

The interests of the patient have primacy in all aspects of the patient-physician relationship. The physician should act as an advocate and coordinator of care for his patient and should assume appropriate responsibility, especially when utilizing the help of other health professionals. The physician should deal only with competent health professionals when sharing the care of the patient. Delegation of treatment or technical procedures must be limited to persons who are known to be competent to conduct them with skill and thoughtfulness; the physician who is primarily in charge of the patient’s care must retain ultimate responsibility for all aspects of the patient’s management. Society has identified the physician as possessing the necessary training to undertake this responsibility and has granted a specific license to exercise this authority and responsibility. This relationship is implied between patient and physician.

... When responsibility for a patient’s care is undertaken by a physician, the physician must exercise ultimate responsibility. Degrees of responsibility must be dictated by the competence of the licensed allied health professionals and the nature of the actual practice setting. Ethical relationships must derive from a sense of mutual respect and a clear delineation of the professional relationship between the physician and the licensed allied health professionals. Competent licensed allied health professionals often add to the quality of care and comfort of patients, thereby expanding the capability of the physician. The patient should be told about the variety and availability of such services, which can be facilitated through cooperation between physicians and licensed allied health professionals.

Quality of Life

Quality of life is the subjective satisfaction expressed or experienced by an individual with his current physical, mental or social situation. Assessment by a physician of a patient’s quality of life can feature prominently in making clinical decisions. It is wise for physicians to be aware of the personal and subjective values that may contribute to such evaluations. Thus, the assessment may vary according to a physician’s age, present health, history of personal illness, cultural background, and long-standing knowledge of the patient as a person. Clinical decisions that hinge on assessing the quality of life should be undertaken with great care and with full cognizance of the subjectivity of the assessment, with full patient participation, or, if that is not possible, with participation of knowledgeable and concerned relatives or guardian. Under ordinary circumstances, a physician’s judgment about the quality of life of a patient should not be unilateral.

Care of the Hopelessly Ill

The relationship between the patient and the physician is based on trust. The physician must be vigilant in seeking objectivity in judging all matters relating to decision making, despite all external considerations. Outside pressure may derive from economic considerations, societal demands (for example, from family members) or from other professional or paraprofessional sources. An institutional ethics committee representing professionals from several disciplines (sociology, ethics, psychology, law, religion) can help by advising the physician on difficult ethical issues.

The physician has a responsibility to ensure that his hopelessly ill patient dies with dignity and with as little suffering as possible. The preference of the patient in regard to use of life-support measures should be given the highest priority. There may be circumstances in which the physician may elect to support the body when clinical death of the brain has occurred, but there is no ethical standard that dictates he must prolong physical viability in such a patient by unusual or heroic means. The lowest threshold of life may be considered a state of irreversible loss of human cognitive or communicative functions and implies that the “person” no longer exists in any significant sense of the term and that awareness of self in relation to surroundings have vanished and never will be experienced again.

Brain Death: “An individual who has sustained either [1] irreversible cessation of circulatory and respiratory function, or [2] irreversible cessation of all functions of the entire brain, including the brain stem, is dead. A determination of death must be made in accordance with accepted medical standards.” (President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research. Defining Death.)
Do-Not-Resuscitate Orders or No-Code Orders: "The purpose of cardiopulmonary resuscitation (CPR) is the prevention of sudden unexpected death. Cardiopulmonary resuscitation is not indicated in certain situations, such as cases of terminal irreversible illness where death is not unexpected." [Standards and guidelines for cardiopulmonary resuscitation (CPR) and emergency cardiac care (ECC). JAMA 1980; 244:453–509]

Cardiopulmonary resuscitation requires the use of appropriate techniques and devices to treat sudden and unexpected cardiac or respiratory arrest by those trained in these techniques. A decision not to attempt resuscitation is the ultimate responsibility of the physician-of-record. Such responsibility cannot be taken over, morally or legally, by institutional committees on ethics or any other person or group of persons who may be available for advice to the physician-of-record.

A decision not to attempt resuscitation and the process of initiating and implementing such action involves clinical and ethical knowledge and judgment; necessary legal knowledge; and, at times, consideration of religious beliefs.

Initiation of the do-not-resuscitate order requires the physician-of-record to review in detail the patient's status: Is the patient terminally ill from an acute or chronic disease?

Having reviewed the data on the clinical status of the patient, the physician must make a judgment as to whether any known treatment can restore the patient to a state of reasonable comfort and function. When treatment is judged useless, writing or giving a verbal order not to resuscitate such a patient is ethical.

A corollary observation: If a physician decides that the disease process or other medical condition that the patient has would not positively be affected by the initiation of resuscitative efforts—in other words, if resuscitative efforts would only prolong the dying process—then a decision to write a do-not-resuscitate order is ethically proper.

A further corollary: It is not ethical to code a patient "do-not-resuscitate" just because he is aged.

If the patient is a mentally competent adult, he has the legal right to accept or refuse any form of treatment, and his wishes must be recognized and honored by his physician. He can decide whether he wishes to be resuscitated when faced with a terminal event. The problem should not be discussed with his family unless the patient authorizes such a discussion. If the patient signifies his preference for a do-not-resuscitate order, this preference becomes the paramount consideration. If the patient's preference is contrary to the desires of his spouse or others, the latter have no legal, ethical, or moral standing to enforce their desires unless a court declares the patient to be legally incompetent and appoints a guardian to make treatment decisions for the patient.

The physician should understand that making decisions about resuscitation does not legally require the counsel or consent of the patient's family, unless a family member is the parent of a minor child or has been appointed the guardian of the
patient's person. Physicians should not breach the confidential nature of the physician/patient relationship by discussing the patient's care with persons who are not authorized by the patient to be made aware of the patient's diagnosis, prognosis, or treatment. Obviously, a competent patient can advise the physician as to with whom his care can be discussed. With the incompetent patient, however, the situation is quite different. In the absence of a medical emergency (in which case the patient's consent to treatment is implied), the physician would be well advised to recommend to the patient's family that they have one of the family appointed as the patient's guardian so that the physician will have a person to deal with who has the legal authority to make treatment decisions for the patient. Physicians should understand that mere blood relationship does not by itself allow a family member to know about or authorize the medical treatment of a patient. Local counsel should be sought to learn the exact parameters of state law on this topic.

For individuals who are mentally defective or deficient and have been declared legally incapacitated, do-not-resuscitate orders must never be written solely on the basis of the mental condition but for the same reasons as for patients who are mentally competent. Legally, when it has been adjudicated that a patient is mentally incapacitated, the only person who can act on his behalf is a guardian or conservator appointed by the court. A relative or friend has no legal right to act for a mentally incapacitated patient unless appointed by the court.

A final corollary: The Federal government and several states and regulatory bodies are recommending or requiring that hospitals maintain committees that create policies, advise physicians, or even make treatment decisions about terminally ill patients, especially newborns. It is too early to predict the long-term effect of such regulations or committees, but physicians are strongly advised to seek legal counsel about the correct state of the law in this very volatile area.

States vary in the time required to appoint a legal guardian or conservator. During that time the physician-of-record can legally exercise his judgment in the care of his incapacitated patient. The physician is the patient's advocate and has a duty to him, and to no other person, during the interim. Full discussion with the spouse or other close relatives about the indications for cardiopulmonary resuscitation, the do-not-resuscitate order, the legal aspects of such orders and the physician's role as the patient's advocate will nearly always result in a decision that is correct ethically.

When a do-not-resuscitate order has been written, the physician must ensure that the patient is as comfortable as possible. A decision to withhold supportive therapy, while ethically sound, may not be acceptable to some families for religious or other reasons. Their wishes must be considered but not necessarily followed. The physician must be the final arbiter in decisions related to a patient, placing the wishes of the patient above all other considerations.
Living Will: The so-called "living will" has excited considerable interest that will continue in the future. Physicians should be aware, however, that fewer than 20 states have enacted statutes making such documents legally enforceable and/or binding on the physician. Physicians who practice in states that have enacted living will statutes are urged to seek local legal counsel as to the exact rights and responsibilities encompassed by that state's statute. The statutes differ markedly between states, and one should not presume that prior experience with one state's statute will be instructive when practicing in another state.

In those states that have not enacted living will statutes or that have expressly provided that living wills are not legally enforceable within that state (even though the document may have been valid in the state in which it was executed), the physician is under no binding legal obligation to follow the instructions or information contained in the document unless the physician has specifically agreed with the patient or guardian to be bound by its content. All physicians would be well advised to be aware of the thoughts and desires of the patient expressed in the document, but need only consider that language to be instructive, and not determinative of the way in which the physician will treat the patient.

Of course, if the physician cannot agree with the restrictions placed on care of the patient by a living will or the statements of the patient or guardian, the physician can withdraw from the case provided that the requirements of local law and practice regarding notice to the patient, continuity of care, and so forth, have been satisfied.

Euthanasia: Active voluntary euthanasia is legally prohibited. However, euthanasia is a classic ethical dilemma that occurs when the ethical responsibility of the physician to preserve life, maintain the quality of life, or both, conflicts with his covenant with the patient who desires an end to pain and suffering that he considers no longer endurable or when immediate family members request termination of life for patients who are comatose or otherwise unable to exercise intellectual control.

The social, religious, and political implications of euthanasia have been discussed exhaustively. They remain controversial and will not be discussed here. While there is no resolution of the problem on ethical grounds, there are major legal prohibitions against euthanasia in the United States today.