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„Medical discretion“ in the patient-physician
relationship

“MEDICAL DISCRETION” IN THE PATIENT-PHYSICIAN RELATIONSHIP

By Albin Eser*

I. INTRODUCTION

At first glance it may seem surprising, if not indeed shocking, that the law intervenes in the patient-physician relationship at all. For in such intimately personal experiences as being sick and dying should not the state hold itself completely out of these matters? Would it not be better to relegate decisions concerning the gray area between life and death to the well-intentioned judgment of the physician? Nothing would oppose this, as long as the trust between doctor and patient remains intact and the one automatically does what the other expects. But what about when these expectations are not fulfilled, or - because of a lack of personal acquaintance or as a result of previous bad experiences - tacit trusting consent does not or no longer exist? As social psychological studies have shown, there are progressively intense degrees of reaction if expectations remain unfulfilled: first of all, “*internalization*”, in which the dissatisfaction is “swallowed”; the second degree is the “*socialization*” of the conflict, in which one “airs” one’s anger and attempts to come to terms with the situation through informal social channels; and finally, the most extreme means is the “*juridization*” of the conflict by taking legal action.¹

The extent to which this means should also be an option in the doctor-patient relationship, then, is the issue here. Free or bound decision, individual responsibility of the physician or professional ethical control, conduct according to conscience or legal directives: these buzzword dyads indicate just a few of the many issues with which the physician sees himself confronted in his decision-making. And this is placed against the background

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¹ Cf. F.X. Kaufmann, “Was Heiss Verrechtlichung Und Wo Wird Sie Zum Problem?”, in *Ärztliches Handeln Zwischen Paragraphen Und Vertrauen* 9-22 (F.X. Kaufmann ed., 1984).

of a medicine which admits even greater possibilities of manipulation - whereby "manipulation" is used here with a completely unpolemic meaning by simply referring to intervention in natural processes: such as reanimation and transplantation, sterilization and fertilization, abortion and perinatology, psychosurgery and sex-change operations, experiments on human subjects and gene manipulation and last but not least in issues entailing euthanasia and assisted suicide. Not only in cases involving such extraordinary procedures, however, but also in the day-to-day routine decisions of patient referral or non-referral, or the continuation or termination of treatment, the physician faces the dilemma of whether or not he may take advantage of opportunities that present themselves: to what extent is he free or bound? How and to whom is he responsible? These problems could be summed up under the rubric of the justifications and limits of *medical discretion* ("*ärztliches Ermessen*"), because - as can often be observed - when the physician demands such "discretion" he appears to assume an "exemption" for himself, which ethicists and legal experts do not always believe they can grant him unconditionally.

Since space does not allow me to examine these principles and misunderstandings individually and in detail,² I would like to focus on two important points used again and again to substantiate the greatest possible freedom for the physician. First, the widespread assertion that medical conduct is determined largely by objective medical facts for which the establishment of norms is elusive; this issue will be disputed with regard to problems determining the concept and criteria of death and the appropriate termination of treatment. Second, the presumed dispensability of legal regulation when the physician is ethically bound by conscience.

II. MEDICAL CONDUCT AS VALUE-FREE CONSEQUENCE OF EMPIRICAL DATA?

Typical for this first issue is the objection which a physician once voiced when I demanded criteria for the termination of treatment: "What do you lawyers actually want to establish norms for? Aren't death and allowing a moribund individual to die pure medical facts simply to be diagnosed and acted upon accordingly, but not to be judged, let alone to be regulated!" Medicine as an objective empirical science, medical measures as implementation of medical data: this is the idea behind such an objection, and

² For further explorations of these issues see A. Eser, "Der Arzt im Spannungsfeld von Recht und Ethik. Zur Problematik 'Ärztlichen Ermessens'", in *Ethische Probleme des Ärztlichen Alltags* 78-103 (O. Marquard, E. Seidler & H.J. Staudinger eds., 1988).

were it correct, it would not only render the establishment of norms unnecessary but would actually prohibit it. But what at first appears to be a pure and simple cogent consequence of value-free medical facts, on closer inspection proves much more complicated: it is a mixture of empirical factors and normative criteria. In order to elucidate this point, two issues generally considered “purely medical” and treated as such will be examined: the moment of death and the termination of treatment.

A. Defining and Establishing Death

As late as the middle of the last century, and even to such a great legal mind as Friedrich Carl von Savigny, death appeared to be “such a simple natural event, that, unlike birth, the exact establishment of its elements is rendered unnecessary”.³ This obviously empirically-descriptive understanding of death can perhaps be better understood when one considers that, at the time of Savigny (early 19th century), cessation of respiration and heartbeat were such “compelling” life-terminating events that there were also no legal issues to quibble about.

However in the meantime, at the very latest with the advent of resuscitation techniques, cardiac death proved to be neither a compelling nor an irrevocable end to a human life and it was established that dying was a process in which the organs and bodily functions could die off somewhat independently from one another and at different times, and that under certain circumstances - especially for transplant purposes - there may even be an interest in maintaining the functional capacity and life of the transplant beyond brain death.⁴

Thus it became necessary for both pragmatic and legal reasons to reconsider the essential criteria which establish death. For in the interest of standardized application as well as determination of the extent to which life-saving directives apply - which determine when basic life-maintenance procedures are required and removal of transplants is forbidden⁵ - a new definition of the moment of death was essential. Highly simplified, this led to a definitional shift from cardiac to brain death as in particular pronounced by

³ Cf. Savigny, 2 *System des Römischen Rechts* 17 (1840). See also F. Fischer, P. Fritzsche & O. Pribilla, “Definition des Todes”, in *Sterbehilfe oder Wie Weit Reicht die Ärztliche Behandlungspflicht?* 26-30 (V. Eid & R. Frey eds., 1978).

⁴ See only J. Wawersik, “Reanimation und Ihre Grenzen”, in *Suizid und Euthanasie als Human-und Sozialwissenschaftliches Problem* 125 et seq. (A. Eser ed., 1976).

⁵ Cf. A. Eser in A. Schönke & H. Schröder, *Kommentar zum StGB* pre-note 16 to § 211 (26th ed., 2000).

the meanwhile generally accepted guidelines developed by the German Surgical Society (*Deutsche Gesellschaft für Chirurgie*).⁶

In the present context the factual correctness of this process (and similar ones as well) is less interesting than the normative content of this definition of death. At first glance it might appear as though the surgeons had actually done nothing other than to descriptively define an empirically factual medical condition, and indeed without a trace of value judgment. Yet this widespread opinion must be considered more closely because it overlooks the fact that underlying the acceptance of "brain death" are premises which are no longer *medical* but can only be considered *normative* in connection with certain value perceptions about human life. This becomes clear when we ask for the legitimacy of even allowing a shift of the moment of death and question why, in the end, the private consensus of a medical organization received the tacit approval of the legal system: the answer lies in the idea that the brain is the seat of human "spiritness" and that this "spiritness" determines "personhood", the essence of a living human being.⁷ At the very latest with this last sentence we crossed over from the realm of pure medical-biological determination to the realm of normative values; for the idea that this "spiritness" specifies "personhood" is not the result of pure description, but rather it is based on an anthropological value judgment which rests on ethical and philosophical opinions which in turn reflect religious beliefs about the world (in the sense of "*Weltanschauung*").⁸

Now we obviously do not intend to suggest that death is a *purely* normative problem - nor is oversimplification in the opposite direction any better. Rather, at least two levels must be distinguished here - again highly simplified - which could be denoted norm *establishment* and norm *application*, with the result that the (normative) *definition* of death (a) and the (clinical) *criteria for determining* death (b) must be differentiated from each other as follows:

a) In so far as the *definition of death* is concerned, the issue of what constitutes the essence of personhood, the irrevocable loss of which would establish death, or the end of personhood, is a question in the *normative*

⁶ Printed in *Der Chirurg* 196 (1968); as to the brain death criteria of the Bundesärztekammer see in *DÄBl* 35-41 (1982). Although not explicitly defining death, the German legislature, too, by constituting certain conditions for the removal of transplants in the new Transplantation Act of 1998 has in fact recognized the concept of brain-death. For details see Eser, *supra* note 5, pre-note 16, 19e to § 211.

⁷ See only P. Bockelmann, *Strafrecht des Arztes* 109 (1968); G. Stratenwerth, "Zum Juristischen Begriff des Todes", in *Festschrift für K. Engisch* 528, 543 (P. Bockelmann *et al.*, eds., 1969).

⁸ Cf. R. Leuenberger, "Probleme um das Lebensende", in *2 Handbuch der Christlichen Ethik* 95 *et seq.* (A.Hertz *et al.*, eds., 1978).

realm: on the basis of customary, professional-ethical and legally recognized convention, which in turn rests on particular anthropological prejudices about personhood, human dignity, etc., we assume that this “spiritness” is the essential characteristic of human life, and consequently a person who has suffered its irrevocable loss could be considered “dead”. Naturally the physician is included in establishing these norms, whereby the term of “establishing” is used here because the “spiritness” is hereby made the determining criterion of personhood, but this is frankly not as much because of his capacity as scientist or physician as it is because of his role as a member of society, which makes him (co-) responsible for the value judgments of the community. While the physician factually has closer contact with the problem and greater expertise in this area than his non-medical counterpart, this does not give him any sort of political-normative legal privilege. The decisive issue in the protection of life, namely what constitutes the essence of personhood, is a political decision in the truest sense of the word, namely from “polis” as a legal community for which all citizens share responsibility - whereby “political” here naturally is not to be misunderstood to refer to its meaning as petty or even party politics, but rather as a basic value decision of the particular legal community (*Rechtsgemeinschaft*).

b) Conversely the *criteria for determining death in an individual case* are concerned with the organ in which human “spiritness” has its biological basis and from which symptoms the irreversible extinguishing of this function can be determined. Regarding these *signs of death*, the physician is needed not in his capacity as citizen but as scientist. For whether and to what extent the brain, as presumptive seat of “spiritness”, still lives, or what symptoms prove its dying, this - at least in principle - is no longer a question of anthropological values but belongs to the realm of the *empirical* natural sciences.⁹

B. Termination of Treatment

Also the question of when the physician may terminate treatment is often viewed as a purely medical affair, which should be the sole responsibility of the doctor.¹⁰ Insofar, however, as this is substantiated by the claim that

⁹ To make things even more complicated, on this factual level a further distinction has to be considered between the empirical criteria of death and the medical methods of establishing them. For more details and references see Eser, *supra* note 5, pre-note 18-19a to § 211.

¹⁰ On this line, in particular the contributions by H.D. Hiersche and H. Tröndle for the 56th German Lawyers Day on “Right to the own Death?”, in *Verhandlungen des 56. Deutschen Juristentages - Berlin* (1986), 2 *Sitzungsberichte*, M7 et seq., 29 et seq. (1986).

allowing a moribund individual to die is a purely medical question in any case, the value judgment implicit in this type of decision is overlooked again.

This is evident in the case of a patient who, as the result of severe brain damage, is unconscious, suffering from an apallic syndrome and slipping away: many believe that this problem can be solved by *shifting the moment of death forward*, so that the patient may already be considered “dead”, with the result that the physician is relieved of his duty to preserve life.¹¹ But as understandable as this position may seem, it would be self-deceptive to believe that shifting the moment of death forward is a value-free decision; in fact, on this basis, the loss of the “spiritness” is no longer the authoritative criterion for death, rather this is shifted to the capacity to communicate, which thereby becomes the definitive essence of “personhood”.

But even when the physician wants to terminate treatment because to him any further medical efforts appear “*futile*”,¹² the decision is determined not only by clinical factors, but in the end also by normative values, specifically those concerning the “meaning of life” (*Lebenssinn*). For even when “meaningless” (*sinnlos*) is understood in a more clinically pragmatic way, such as meaning further treatment is “pointless” (*zwecklos*) or “hopeless” (*aussichtslos*), this decision is dependent on the designated *goals*: in so far as these only concern the determination that this goal is no longer attainable, it is truly a “purely clinical finding”. On the other hand, insofar as it involves the *determination* of goals (which are then deemed unattainable), there are also normative elements at play. This distinction can easily be established by asking the physician about the circumstances under which he would consider further life-sustaining measures “meaningless” (*sinnlos*) or “pointless” (*zwecklos*):¹³ if his answer is that he would be prepared to terminate life-sustaining treatment only when, in spite of clinical measure, death is imminent, then he recognizes *life as such*, independent of any sort of communicative capacity. Conversely, if the physician is prepared to terminate treatment already when the basic ailment is diagnosed as incurable, and life-sustaining therapy would simply prolong the agony of death, or if, in the case of a cancer patient, he allows a patient subsequently afflicted by a secondary pulmonary infection to die before regaining consciousness and learning of this hard and inevitable fate, this indicates a more *qualitative view of life*, and indeed a different set of values than in the previous example.¹⁴ Or

¹¹ For tendencies like that (though not personally sharing this view) cf.: A. Eser, in A. Auer, H. Menzel & A. Eser, *Zwischen Heilaufrag und Sterbehilfe* 120, n. 163 (1977).

¹² For reference material see *ibid.*, at 126, n. 182.

¹³ *Ibid.*, 126 *et seq.*

¹⁴ Cf. A. Auer, “Begrenztes Leben – Sinnvolles Leben?”, in 33 *Renovatio* 97 *et seq.* (1977); R. Leuenberger, *supra* note 8, at 98, 106 *et seq.*

if the physician would allow a crippled newborn to die because he feels the need to spare the child his difficult fate as well as relatives and society the disproportionate expense for care, then this judgment - aside from assuming stewardship over another life ("I know what's good for you better than you do!") - entails a *relativization* of human life; for as soon as the maintenance of a life becomes dependent on factors other than the patient's own interests, the value of life becomes a measurable, calculable and, thus, a relative worth which could presumably be ranked even below material interests.

C. The Physician's Task on the Basis of the Establishment of Normative Goals

These examples could be added to at will, but the point to be made should be clear already: what at first glance appears to be purely a compulsory consequence of medical facts, on closer inspection proves to be normatively prejudiced. Whether consciously or not, the physician bases his decisions on certain established objectives which in turn reflect values about - among other things - the "personhood" of humans, quality of life, and the duties to heal and ease pain.

In the end this should not be surprising, because medical conduct as interpersonal interaction is accomplished as the result of a specific set of objectives which has changed over and over again throughout the history of medicine, on the one hand, due to scientific and technological advances, and on the other, according to changes in the system of values. To which objectives a particular physician or medical profession feels responsible is - whether explicit or tacitly understood - the result of consensus and decision and therefore a normative act.¹⁵

III. IS THE LAW DISPENSABLE WHEN THE PHYSICIAN IS ETHICALLY BOUND BY CONSCIENCE?

Since it has turned out that medical conduct also contains a *normative* element, naturally the question arises as to who the *normgiver* is: Should each physician be permitted to act according to his personal morals? Or only in agreement with a particular - and if so which - religious ethic or "*Weltanschauung*"? Or only in connection with a particular "recognized" professional code of ethics? Or should it be determined by legal norms? And

¹⁵ Cf. V. Eid, "Muss Die Medizin Alles Tun, Was Sie Kann?", in *Sterbehilfe oder Wie weit Reicht die Arztliche Behandlungspflicht?* 115, 117-18 (V. Eid & R. Frey, eds., 1978).

if not solely according to autonomous established norms, how concretely, how binding and how enforceable? With what sanctions?

Of this multitude of questions only the juridically and politically most important can be addressed here: to what extent would the establishment of legal norms for medical conduct be dispensable given that the physician feels bound by his conscience and/or his professional code of ethics? Or conversely: On what grounds would the physician, in exercising judgment and practicing medicine, need to feel an obligation not only to his conscience and/or his professional ethics, but must also be bound by heteronomously established and, if necessary, sanctionable legal norms? Basically there are four legal functions which are essential to medical conduct, and which will thus be addressed briefly here: the protection function; prevention of abuse; establishment of guidelines; stabilization of trust.

A. The Protective Function of the Law

By being admitted to the practice of medicine the physician is given access to treat the human body, a legal interest which - as in most Constitutions - enjoys special protection under the German Basic Law (*Grundgesetz*): human dignity, body and life, and self-determination (Articles 1, 2, *Grundgesetz*).¹⁶ This reason alone is sufficient to establish that "legally free" medical judgment, in the sense that the physician be bound - perhaps strictly, perhaps laxly - simply by his own conscience and not be held legally accountable for his actions, is fundamentally unacceptable. Such an "exemption" with respect to the law would dismiss the fact that the legal system is not permitted to hand over human life freely, rather retains final responsibility for its protection, even if this can only be accomplished by obligating the medical profession to abide by certain closely guarded fundamental rules, the disregard of which would result in sanctions.

B. Preventing Abuse

By the same token, the notion of preventing abuse comes in. In order to provide effective protection, legally established norms need to be *enforceable* and infringement must be *sanctionable*. For the law - and in particular criminal law, which is by its very nature "distrusting" - cannot exclusively orient itself on the well-intentioned physician, but must also anticipate the doctor who might abuse his privilege of intervention. But more important

¹⁶ For more details see A. Eser, "Medizin und Strafrecht: Eine Schutzgutorientierte Problemsübersicht", in 97 *Zeitschrift für die Gesamte Strafrechtswissenschaft (ZStW)* 1-46 (1985).

than the pursuit of individual "black sheep", from which no profession is exempt, is the generally preventive prophylactic: the evaluative and determinative effect which results from legal norms. This is above all important in domains in which the (professional) ethic alone does not appear to be sufficiently effective: What, for instance, would happen to the patient's right to self-determination if the judiciary would not always insist on the duty to inform? What challenges would the medical duty of care face if liability for medical malpractice were to disappear? Whoever swears by self-responsibility in the medical profession overlooks the consequences for the patient: the more individual responsibility of the physician remains unsanctionable and therefore without legal risk, the more the patient is virtually unprotected.¹⁷

C. Providing Guidelines

Of course the law's function would be significantly curtailed if it were reduced to its negative function of preventing abuse. Much more important is one of its positive functions: clarifying guidelines in controversial legal situations, which is indeed as much in the general interest of most uniform practice possible as in the interest of the individual physician, for whom legal clarification can signify an unburdening as well.

A showcase example is, at least for Germany, the lack of regulation regarding sterilization,¹⁸ where even clear pronouncements in the professional medical code do not seem to guarantee generally acceptable application because they are too narrow.¹⁹ And in the case of termination of treatment, significantly divergent decisions are still evident.²⁰ It is not as though these could be eliminated by a casuistic roster of values because consensus seems to grant the physician a certain (though not complete) degree of freedom in his judgments in the gray area between life and death. However this does not preclude, but rather presumes, that the physician understands at least the most important decisive criteria. Or should it really be left to the personal good intentions of the individual physician to decide what still qualifies as "meaningful" effort and what is already "meaningless"? Or whether the point at which termination of treatment is justified has already been reached when the basic ailment is diagnosed as incurable or only once

¹⁷ Cf. also H.J. Hirsch, "Strafrecht und Rechtsfreier Raum", in *Festschrift für P. Bockelmann* 89 et seq., 99 et seq., 133 et seq. (A. Kaufmann et al., eds., 1979).

¹⁸ See 20 *Entscheidungen des Bundesgerichtshofes in Strafsachen (BGHSt)* 81 (1966).

¹⁹ Cf. R. Wille, *Nachuntersuchungen an Sterilisierten Frauen* 131 et seq. (1978); A. Eser & H.G. Koch, "Aktuelle Rechtsprobleme der Sterilisation", in 2 *Medizinrecht* 6-13 (1984).

²⁰ Cf. *ibid.*, at II.2.

the loss of consciousness is irrevocable, whether to allow physically or mentally impaired newborns to die, or whether life-support is dependent on material considerations, or whether or to what extent the wishes of the patient and/or his relatives should be respected? If the differing practices regarding these issues still are in general simply accepted, then this results not least of all from the public's unawareness of the problem and from the understandable repression of these unpleasant topics.

But can a legal community (in terms of "Rechtsgemeinschaft") really afford to leave the application of such fundamental values to the practicing physician simply because it finds the issues distasteful? Or would not the physician also have an interest in having established criteria according to which he can determine his conduct, knowing that he is in consonance with his colleagues and in accord with the code of law?

D. Stabilization of Trust

Those considerations would also be important for another reason: in order to stabilize trust in the relationship between doctor and patient. Perhaps this fourth point is even the most important function of law in the clinical domain: that the patient can have confidence that medical conduct, performed wherever and by whomever, is subject to the same basic principles and criteria. When the patient can assume that this doctor and that hospital will provide him with care or allow him to die in peace according to the same set of standards as anyone else and anywhere else, only then can the "accepted dependence" (Dietrich Rössler), which is so important for the trust between doctor and patient, be established.²¹ This sort of trust cannot be won as long as the patient is under the impression that the individual doctor's own responsibility is the only factor which determines what "meaningful" effort is understood to be.

This clearly seems to contradict to the fact that the currently observable trend toward the disappearance of trust is traced back to an increasing "juridization" of the doctor-patient relationship, the favorite reference being the over emphasized duty to inform. But could it not also be that cause and effect are being reversed here? Under normal circumstances it is not the law which creates bad situations but conversely a bad situation which provokes the call for law. This can most conveniently be demonstrated in the case of

²¹ D. Rössler, "Ärztliche Ethik in Anthropologischer Sicht", in *Ärztliche Ethik* 23-24 (R. Gross *et al.*, eds., 1978).

the epithetical “Zuchtrute der Justiz” (disciplining rod of justice),²² namely the duty to inform: for would it not have been so extremely difficult to hold a once-closed “collegiality” of medical professionals accountable for malpractice, the judiciary had not had to seek the difficult way out via insufficient disclosure in order to help the patient to secure his rights.²³ Certainly this may lead to juristic exaggerations every now and again, but if one searches for the primary cause of such an escalation, could one really hold the lawyers' passion for juridization accountable, or dissatisfied patients' passion for revenge? Or perhaps more likely the realization that the doctor himself, even in the face of obvious mistakes, often has great difficulty in actually taking on the “responsibility” sworn before?

When patients as a group become increasingly less shy about actually demanding that doctors actually take on their responsibility, this could, at least in part, be the result of the *commercialization of medicine*. Whereas in earlier times the doctor was perceived as a helper who seemed to be above profane profit motive and whose “fee” (“Honorierung”) was still understood as an honorary remuneration of a debt of thanks, today, because of formalized rates, but even more so because of (additional) agreed-upon fees, a contractual moment has invaded the doctor-patient relationship so that it is now no longer distinguishable from other business agreements in the service industry. This “materialization” (*Versachlichung*) of medical service is specifically increased by medical specialization in certain organs: the doctor no longer appears as all-around “life-helper” but as a repairman for hearts or kidneys. But if the specialist has to be paid good money, the client expects good service and replacement in case something goes wrong. In addition, the practice, now common in larger clinics, at least in Germany, of requiring patients to sign a “substitute agreement” (*Vertreterklausel*), which indicates willingness be treated by any doctor on duty, and not necessarily the head doctor, for whom the patient may have selected this clinic, does not exactly aid the cause of stabilizing trust. For along with the “substitutability” of that whom one specifically sought out for help, medical service also becomes “substitutable” and because of this exchangeability becomes “depersonalized”.

When the law tries to occupy this vacuum, it is not in order to suppress existing trust, but rather to at least replace that which is non-existent with general rules of conduct. In a comparable context, the American patient's “Bill of Rights” did not come into being in order to destroy trust, but rather

²² Cf. H. Kuhlendahl, “Ärztlicher Entscheidungsspielraum – Handlungszwänge”, in *Festschrift für P. Bockelmann*, *supra* note 17, at 471.

²³ As an example for such “collegiality” see Bundesgerichtshof, in 28 *Neue Juristische Wochenschrift* 1463-64 (1975).

because this trust was already vanishing. The prevention of such a loss of confidence is the aim of requiring doctors to abide by general criteria which are not only determined by their own conscience but are also legitimized by their legal foundation. This is all the more necessary when the patient no longer has to deal with his "one trusted doctor", with whose basic ethics he may have been familiar, but where the patient is confronted with a whole team of doctors whose "collective conscience" he understandably would like to see defined by binding criteria for decision-making. And last but not least this trust in uniform conduct which conforms to law, is also in the public interest; for when the State by its law allows a life to be entrusted to a physician, it can only do this under the condition that each and every doctor is obligated to abide by the criteria which the legal community views as being in the interest of optimal protection of life and death with dignity.