

MEDICAL AND CHIRURGICAL FACULTY OF MARYLAND  
\*ETHICAL OPINIONS SECTION 100\*

100. PHYSICIAN/PATIENT RELATIONSHIP

101. FREE CHOICE OF PHYSICIAN AND PATIENT; TREATMENT OF CONTAGIOUS PATIENTS

.01 A physician may freely choose the patients he or she wishes to treat. However, this right may be limited under the law in circumstances that involve illegal discrimination. Risk to the physician should not be the sole reason a physician refuses care. A physician is obligated to render emergency care in situations where other adequate emergency services are not available although physicians are not obligated to risk undue needless exposure to a proximate threat to their health. (MC 3/18/69; Revised 6/26/86; Council 11/21/87, ratified by HOD 9/8/96; PEC 4/23/02, ratified by HOD 10/17/04)

.02 A patient is entitled to freely choose a physician. A patient may abrogate this right by contract. This right may be limited by hospital privileges. (MC 10/4/61; Revised 6/26/86; Council 11/21/87; ratified by HOD 9/8/96, PEC 4/23/02, ratified by HOD 10/17/04)

.03 If a physician feels the need to refer a patient or feels incapable of providing adequate care to a patient, the referring physician has a duty to refer the patient to qualified specialists. Should a physician and patient disagree, the physician should explain the choice of referral. Physicians must disclose any financial inducements that may tend to limit the diagnostic and therapeutic alternatives that are offered to patients or that may tend to limit patients' overall access to care. However, the choice is ultimately the patient's. (Revised 6/26/86; Council 11/21/87; PEC 11/6/95; ratified by HOD 9/8/96, PEC 4/23/02, ratified by HOD 10/17/04)

102. TERMINATION OF PHYSICIAN/PATIENT RELATIONSHIP

.01 A physician may choose, for whatever reason, to terminate the relationship with a patient. However, a physician may not terminate patient care if to do so would deprive the patient of needed care. Should termination become an issue under circumstances of immediate critical care, ongoing care must be obtained prior to terminating the patient. In other circumstances notice to the patient and resources for referrals may be given. (Council 6/26/86; ratified by HOD 9/8/96, PEC 4/23/02, ratified by HOD 10/17/04)

.02 Although a hospital by its bylaws may make the responsibility for patient care more demanding (for example, an on call physician may be required to provide initial follow up care to the E.R. patient), the physician's responsibility cannot be abrogated by the bylaws. (Council 9/14/89)

.03 Should a physician make a decision to terminate the relationship with a patient, the

physician should notify the patient in writing. Proper notice requires the letter<sup>1</sup> to be sent in a manner that allows a patient sufficient time to locate another physician. For example, up to four weeks in an urban or suburban location or four to six weeks in a rural area is considered sufficient notice to a patient. It is recommended that the letter be sent by certified mail(Council 6/26/86; ratified by HOD 9/8/96, PEC 4/23/02, ratified by HOD 10/17/04)

103. PRONOUNCEMENT OF DEATH

Maryland law states that a determination of death should be based “on ordinary standards of medical practice” although, maryland law specifies no particular person to pronounce death unless exceptional circumstances warrant otherwise, a body should be identified, viewed, and death verified by a physician. An exception to this directive may occur, if a physician has seen a patient whose death is reasonably anticipated. In that case, a person who is capable of recognizing cessation of respiration and heart beat may verify death for the physician and so advise him or her in a reasonable period of time. (EC 6/17/71; PEC clarification 12/3/85; Council 9/14/89 ratified by HOD 9/8/96, PEC 4/23/02, ratified by HOD 10/17/04)

104. RELEASE OF INFORMATION

Except as provided by law or as authorized by patient, a physician should not release medical information about a patient to any person. *SEE*, Medical Records, Confidentiality and Disclosure in the MedChi Resource Directory. (Council 6/29/89; 9/14/89; ratified by HOD 9/8/96, PEC 4/23/02, ratified by HOD 10/17/04)

105. USE OF CHAPERONES

In deciding whether to use a chaperone during an examination or other procedure, the physician must be cognizant that the physician/patient relationship is an important one in which both the physician and the patient are subject to individual vulnerability. Due to the variety of situations and relationships that a physician must face, each physician must exercise his/her own professional judgment in deciding whether to have a chaperone present during treatment of the patient. Among the factors which each physician should consider before making such a decision are: the gender of the patient, the type of examination or procedure being administered, the need for the patient to be disrobed, the personality and sensibilities of the patient, and the length of time the physician has been treating the patient. The use of a chaperone is for the protection of both the patient and the physician. In all instances, it is incumbent upon the physician as a professional, to strive to conduct himself/herself in a manner that is above reproach and beyond the appearance of impropriety. (PEC 11/1/83; ratified by HOD 9/8/96, PEC 4/23/02, ratified by HOD 10/17/04)

---

<sup>1</sup> Sample termination of care form letter: Dear (patient name): This is to inform you that I can no longer be your treating physician as of (insert date\*) because (insert reason, optional). You might wish to call the county medical society for names of physicians in the area (insert telephone number).

106. REFERRALS AND CONSULTATIONS

- .01 The patient's best interests are served when a consulting physician notifies the primary care and/or treating physician of any diagnoses or treatments. If the patient objects, the physician should explain the importance of such notification. If the patient still objects, the physician should either treat the patient within the limitations set by the patient, or withdraw from the case according to guidelines as set forth in §102 above as well as other appropriate professional directives. (MC 12/11/63; *Compendium* Revision 1984; Council 11/21/86; ratified by HOD 9/8/96, PEC 4/23/02, ratified by HOD 10/17/04)
- .02 However, if the patient is referred by a third party, such as an attorney or insurance company for evaluation as opposed to treatment, the physician may evaluate the patient's condition without first informing the treating physician. Should this third party request that the patient bring a witness to the examination, it is the physician's decision whether to evaluate the patient under these circumstances. (MC 7/12/65; *Compendium* Revision 1984; Council 11/21/86)

107. PATIENT TRANSFERS

Some circumstances may warrant a medically hazardous transfer from one medical facility to another that is more appropriate to the medical needs of the patient; for example, when a seriously burned patient must be transferred to a special burn unit. However, a physician should not make a medically hazardous transfer of a patient from one medical facility to another solely for economic reasons. This prohibition applies whether the transfer request originates from another physician, the hospital administration, or a third party payor. Whenever a transfer between medical facilities is necessary, the physician should: examine the patient, stabilize the patient when possible, notify the receiving facility, ascertain that a physician or other authorized person at the receiving facility has accepted the transfer, and, when necessary, assure that appropriate medical personnel accompany the transferred patient to the receiving facility. (PEC 1983) (*Note*: Patient transfers should also be considered in light of EMTALA legislation which pertains to patients in emergency status or active labor.)(Affirmed PEC 11/6/95; ratified by HOD 9/8/96)

108. ABANDONMENT

When a physician is away from his or her practice or otherwise unavailable, it is his/her responsibility to make suitable arrangements with another physician or group of physicians. This information must be readily available to patients. Failure to make suitable arrangements could be construed as abandonment. For example, a recorded message on a physician's telephone simply advising patients to go to an emergency room is unsuitable and could be construed as abandonment unless the emergency room has an explicit agreement with the physician for this referral. (PEC 11/15/84; 11/6/95, ratified by HOD 9/8/96, PEC 4/23/02, ratified by HOD 10/17/04)

109. SECOND OPINIONS

- .01 The patient has the right to choose his or her physician unless the patient agrees to limit the choice by contract.

- .02 When a second opinion is required by an insurance or similar program, both the treating physician and the second physician should explain their respective roles to the patient. The second physician should not actively encourage or induce the patient to change physicians.
- .03 Should the patient freely choose to transfer his or her medical care, the second physician may accept the patient. The treating physician should honor the patient's choice.
- .04 Should the second physician disagree with the treating physician's opinion, a third opinion should be suggested. Whatever the outcome, the second physician should strive to communicate with the treating physician and avoid, if at all possible, a real or apparent conflict of interest. (PEC 6/27/85, ratified by HOD 9/8/96, PEC 4/23/02, ratified by HOD 10/17/04)
- .05 Second surgical opinion. A physician who renders a second surgical opinion may be asked to assist in the surgery. While not in and of itself unethical, the situation presents great opportunity for abuse. Accordingly, a physician rendering a second surgical opinion should only assist in that surgery if no other qualified physician is available. (Council 1/23/88; ratified by HOD 9/8/96)

110. DISCLOSURE OF OFFICE POLICIES

A physician's office of any type (private, walk-in clinic, etc.) should disclose in a reasonable fashion its contractual limitations to patients or potential patients at the earliest possible moment. Such limitations would include: payment policies, representative fees, office hours, type of care rendered, charges for missed appointments, charges for telephone calls and types of insurance accepted. (PEC 1/24/85; 11/6/95; ratified by HOD 9/8/96)

111. ETHICAL RESPONSIBILITY OF TREATING PHYSICIAN AS A WITNESS IN LITIGATION INVOLVING A PATIENT

In any litigation in which a patient's medical condition is at issue and that discloses the nature of the relationship of the physician to his or her patient, the physician should comply with all applicable legal mandates regarding the disclosure of protected health information and should also be aware of the guidance offered by the ethical codes of his or her own specialty. The testimony of the physician is expected to be honest. (Council 3/26/88, ratified by HOD 9/8/96, PEC 8/27/02, ratified by HOD 10/17/04)

112. SALE OR CLOSING OF MEDICAL PRACTICE

Whenever a physician's medical practice is closed or sold, notice to patients and continuity of care must be the primary concerns. Active patients should be notified as soon as possible. This may be accomplished by several different methods, including, but not limited to, the following:

- A. Letter or postcard;

- B. Newspaper ad;
- C. Answering machine.

Physician's death or illness. Should a sudden need arise to close a practice due to a physician's sudden death or illness, the personal representative should consult the physician or physician's will for direction. A physician should address this issue in his or her will or a letter of instruction in order that the personal representative have some direction in the event of his or her death.

If a physician's will or letter of instruction does not address this issue, the personal representative can either approach another physician to assume the practice and notify the patients, or approach the medical society for assistance. (PEC 3/26/88 ratified by HOD 9/8/96, PEC 4/23/02, ratified by HOD 10/17/04)

113. **DISSOLUTION OF MEDICAL PRACTICE; TERMINATION OF PHYSICIAN EMPLOYEE**

When physicians dissolve a professional corporation or partnership, or when a physician group discharges a physician employee, the patient's best interest must be paramount, regardless of the dispute that may arise in such situations. It would be desirable to have this resolved in the agreement when the corporation is created. (PEC 4/23/02, ratified by HOD 10/17/04)

The notice of the change in providers should be provided to patients in a timely manner. It should indicate the date of the dissolution or discharge, the address, and telephone number of the physician(s) who will be available for continued patient care. If the departing physician(s) is(are) continuing practice, the address and telephone number of the departing physician(s), when known, should be made available to patients for continued care.

Appropriate instructions should be given to the office staff concerning the handling of patients' questions. All physicians involved should act in a fair and professional manner. The patient must always have free choice of physician unless the patient has limited this right by contract with an alternative delivery system. (Council 2/12/87; ratified by HOD 9/8/96)

114. **SELF-TREATMENT OR TREATMENT OF IMMEDIATE FAMILY MEMBERS**

Physicians generally should not treat themselves or members of their immediate families. Professional objectivity may be compromised when an immediate family member or the physician is the patient; the physician's personal feelings may unduly influence his or her professional medical judgment, thereby interfering with the care being delivered. Physicians may fail to probe sensitive areas when taking the medical history or may fail to perform intimate parts of the physical examination. Similarly, patients may feel uncomfortable disclosing sensitive information or undergoing an intimate examination when the physician is an immediate family member. This discomfort is particularly the

case when the patient is a minor child, and sensitive or intimate care should especially be avoided for such patients. When treating themselves or immediate family members, physicians may be inclined to treat problems that are beyond their expertise or training. If tensions develop in a physician's professional relationship with a family member, perhaps as a result of a negative medical outcome, such difficulties may be carried over into the family member's personal relationship with the physician.

Concerns regarding patient autonomy and informed consent are also relevant when physicians attempt to treat members of their immediate family. Family members may be reluctant to state their preference for another physician or decline a recommendation for fear of offending the physician. In particular, minor children will generally not feel free to refuse care from their parents. Likewise, physicians may feel obligated to provide care to immediate family members even if they feel uncomfortable providing care.

It would not always be inappropriate to undertake self-treatment or treatment of immediate family members. In emergency settings or isolated settings where there is no other qualified physician available, physicians should not hesitate to treat themselves or family members until another physician becomes available. In addition, while physicians should not serve as primary or regular care providers for immediate family members, there are situations in which routine care is acceptable for short-term, minor problems.

Except in emergencies, it is not appropriate for physicians to write prescriptions for controlled substances for themselves or immediate family members. Physicians may prescribe medications for family members and for themselves subject to the limitation imposed by state law and the AMA. Renewal of long term stable prescriptions is acceptable as long as there is a process for periodic evaluation by a physician who is not a family member. (PEC 4/7/98, ratified by HOD 10/17/04)

**\*\*\*This section was approved by the House of Delegates on October 17, 2004\*\*\***