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### AMA CODE SAYS

#### AMA Code of Medical Ethics' Opinions About End-of-Life Care and Death

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##### Abstract

Death determination is fraught with clinical, cultural, and ethics questions. This article considers relevant history that informs the AMA Code of Medical Ethics opinions about neurological criteria for death.

##### From Heart to Brain

Diagnosing death became significantly more complex as science revealed more about physiological relationships between the brain and body. The mainstream clinical consensus up to the early 1960s was that a patient died upon cessation of cardiopulmonary function, as indicated by absence of a palpable pulse or, later, by absence of a pulse discernible via stethoscope.<sup>1</sup> In the late 19th century, physicians reported observations about relationships between brain function and other critical bodily functions, notably respiration.<sup>2</sup> By the 1950s, failing critical cardiopulmonary function could be supported by innovations, such as positive-pressure ventilation,<sup>3</sup> which gave rise to new philosophical and clinical questions about the nature and scope of medicine's role in patients' transitions from life to death. Through the 1960s, the connection between the cessation of critical bodily functions and of **brain function** became clearer from a neurological perspective,<sup>2</sup> and, in 1968, the Ad Hoc Committee of the Harvard Medical School to Examine the Definition of Brain Death introduced *brain death* as a legitimate definition of death.<sup>4</sup>

##### Guidance

Patients, however, are generally not concerned with what constitutes death from neurological or cardiopulmonary standpoints. More often, patients want to know whether, after a lifesaving intervention, they'll walk, talk, be awake, be able to do what they care about doing, and be able to interact with people they care about. For patients, diagnoses tend to matter less than their visions of their future experience of illness and treatment. Even for patients who want "everything done," the physiological dimension of exceptional circumstances is rarely specified. "Do everything, unless I meet criteria for cardiopulmonary death," for example, is not a commonly articulated wish. These realities of patients' experiences underscore the importance of **advance care planning** and end-of-life decision making; guidance on these subjects is offered in the American Medical Association (AMA) Code of Medical Ethics opinions related to death.

Opinion 5.1, "Advance Care Planning," encourages physicians and patients to consider goals of care and to plan "in advance for decisions about care in the event of a life-

threatening illness or injury.”<sup>5</sup> The purpose of advance care planning is to generate discussion among patients, their surrogate decision makers, their loved ones, and health professionals about patient values and preferences that should inform the clinical dimensions of EOL care and death. Physicians are encouraged to “be sensitive to each patient’s individual situations and preferences” and to consider factors that could affect patients’ decision making, such as “culture, faith traditions, and life experience.”<sup>5</sup> Physicians can also use advance care planning time “to address patients’ concerns and expectations and clarify misunderstandings individuals may have about specific medical conditions or interventions.”<sup>5</sup>

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### Conflict of Interest Disclosure

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