REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS

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Subject: Pandemic Ethics and the Duty of Care (D-130.960)

Presented by: Alexander M. Rosenau, DO, Chair

Policy D-130.960, "Pandemic Ethics and the Duty of Care," adopted by the American Medical Association (AMA) House of Delegates in June 2021, asks the Council on Ethical and Judicial Affairs to "reconsider its guidance on pandemics, disaster response and preparedness in terms of the limits of professional duty of individual physicians, especially in light of the unique dangers posed to physicians, their families and colleagues during the COVID-19 global pandemic."

A CONTESTED DUTY

As several scholars have noted, the idea that physicians have a professional duty to treat has waxed and waned historically, at least in the context of infectious disease [1,2,3]. Many physicians fled the Black Death; those who remained did so out of religious devotion, or because they were enticed by remuneration from civic leaders [1]. Even in the early years of the AIDS epidemic, physicians contested whether they had a responsibility to put themselves at risk for what was then a lethal and poorly understood disease [3]. Yet the inaugural edition of the AMA *Code of Medical Ethics* in 1847 codified a clear expectation that physicians would accept risk:

> When pestilence prevails, it is [physicians'] duty to face the danger, and to continue their labors for the alleviation of suffering, even at the jeopardy of their own lives [1847 Code, p. 105].

That same sensibility informs AMA's Declaration of Professional Responsibility when it calls on physicians to "apply our knowledge and skills when needed, though it may put us at risk." And it is embedded in current guidance in the *Code*. Based on physicians' commitment of fidelity to patients, Opinion 8.3, "Physicians' Responsibilities in Disaster Response and Preparedness," enjoins a duty to treat. This opinion provides that "individual physicians have an obligation to provide urgent medical care during disasters . . . . even in the face of greater than usual risks to physicians' own safety, health, or life." The *Code* is clear that this obligation isn't absolute, however. Opinion 8.3 qualifies the responsibility when it notes that "physicians also have an obligation to evaluate the risks of providing care to individual patients versus the need to be available to provide care in the future."

From the perspective of the *Code*, then, the question isn't whether physicians have a duty to treat but how to think about the relative strength of that duty in varying circumstances.

INTERPRETING ETHICS GUIDANCE

Over the course of the COVID-19 pandemic, AMA has drawn on the *Code* to explore this question in reflections posted to its COVID-19 Resource Center on whether physicians may decline to treat unvaccinated patients and under what conditions medical students may ethically be permitted to graduate early to join the physician workforce.

Drawing particularly on guidance in Opinion 1.1.2, "Prospective Patients," and—in keeping with Opinion 8.3, taking physicians' expertise and availability as itself a health care resource—Opinion 11.1.3, "Allocating Limited Health Care Resources," as well as Opinion 8.7, "Routine Universal Immunization of Physicians," these analyses offer key criteria for assessing the strength of the duty to treat:

- urgency of medical need
- risk to other patients or staff in a physician's practice
- risk to the physician
- likelihood of occurrence and magnitude of risk

To these criteria should be added likelihood of benefit—that is, physicians should not be obligated to put themselves at significant risk when patients are not likely to benefit from care [2]. Although the *Code* does not link the question specifically to situations of infectious disease or risk to physicians, it supports this position. Opinion 5.5, "Medically Ineffective Interventions," provides that physicians are not obligated to provide care that, in their considered professional judgment, will not provide the intended clinical benefit or achieve the patient's goals for care.

Similarly, to the extent that the *Code* articulates a general responsibility on the part of physicians to protect the well-being of patients and staff, it supports consideration of risk to others in assessing the relative strength of a duty to treat. Thus, while Opinion 1.1.2 explicitly prohibits physicians from declining a patient based solely on the individual's disease status, it permits them to decline to provide care to patients who threaten the well-being of other patients or staff. In the context of a serious, highly transmissible disease this responsibility to minimize risk to others in professional settings may constrain the presumption of a duty to treat.

Yet the *Code* is also silent on important matters that have been noted in the literature. For example, it doesn't address whether the duty to treat applies uniformly across all medical specialties. Some scholars argue that the obligation should be understood as conditioned by physicians' expertise, training, and role in the health care institution [4,5,6]. In essence, the argument is that the more relevant a physician's clinical expertise is to the needs of the moment, the more reasonable it is to expect physicians to accept greater personal risk than clinicians who don't have the same expertise. The point is well taken. Guidance that addresses the duty to treat "as if it were the exclusive province of any individual health profession" [2], risks undercutting its own value to offer insight into that duty.

Moreover, for the most part the *Code* restricts its analysis of physicians' responsibilities to the context of their professional lives, addressing their duties to patients, and to a lesser degree, to their immediate colleagues in health care settings. In this, guidance overlooks the implications of responsibilities physicians hold in their *nonprofessiona*l lives—as members of families, as friends, as participants in community outside the professional domain. Thus, it is argued, a physician whose household includes a particularly vulnerable individual—e.g., someone who has chronic underlying medical condition or is immune compromised and thus at high risk for severe disease—has a less stringent duty to treat than does a physician whose personal situation is different.

Although the *Code* acknowledges that physicians indeed have lives as moral agents outside medicine (Opinion 1.1.7, "Physician Exercise of Conscience"), it does not reflect as deeply as it might about the nature of competing personal obligations or how to balance the professional and the personal. In much the same way as understanding the duty to treat as the responsibility of a single profession, restricting analysis to a tension between altruism and physicians' individual self-

interest "fails to capture the real moral dilemmas faced by health care workers in an infectious epidemic" [7].

SUPPORTING THE HEALTH CARE WORKFORCE

As adopted in 1847, the *Code* addressed physicians' ethical obligations in the broader framework of reciprocal obligations among medical professionals, patients, and society. Over time, the *Code* came to focus primarily on physician conduct.

Pandemic disease doesn't respect conceptual boundaries between the professional and the personal, the individual and the institutional. Nor does it respect the borders of communities or catchment areas. In situations of pandemic disease, "the question is one of a social distribution of a biologically given risk within the workplace and society at large" [7].

Health Care Institutions

Under such conditions, it is argued, the duty to treat "is not to be borne solely by the altruism and heroism of individual health care workers" [7]. Moreover, as has been noted,

> … organizations, as well as individuals, can be virtuous. A virtuous organization encourages and nurtures the virtuous behavior of the individuals within it. At the very least, the virtuous institution avoids creating unnecessary barriers to the virtuous behavior of individuals [2].

The *Code* is not entirely insensitive to the ethics of health care institutions. It touches on institutions' responsibility to the communities they serve (Opinion 11.2.6, "Mergers between Secular and Religiously Affiliated Health Care Institutions"), and to the needs of physicians and other health care personnel who staff them (Opinions 11.1.2, "Physician Stewardship of Health Care Resources," and 11.2.1, "Professionalism in Health Care Systems). Health care facilities and institutions are the locus within which the practice of today's complex health care takes place. As such, institutions—notably nonprofit institutions—too have duties,

> … fidelity to patients, service to patients, ensuring that the care is high quality and provided "in an effective and ethically appropriate manner"; service to the community the hospital serves, deploying hospital resources "in ways that enhance the health and quality of life" of the community; and institutional stewardship [CEJA 2-A-18].

Analyses posted to the AMA's COVID-19 Resource Center look to this guidance to examine institutional obligations to protect health care personnel and to respect physicians who voice concern when institutional policies and practices impinge on clinicians' ability to fulfill their ethical duties as health care professionals.

Although existing guidance does not explicitly set out institutional responsibility to provide appropriate resources and strategies to mitigate risk for health care personnel, it does support such a duty. The obligation to be responsible stewards of resources falls on health care institutions as well as individuals. To the extent that health care professionals themselves are an essential and irreplaceable resource for meeting patient and community needs, institutions have an ethical duty to protect the workforce (independent of occupational health and safety regulation). On this view, institutions discharge their obligations to the workforce when, for example, they

- support robust patient safety and infection control practices
- make immunization readily available to health care personnel

- provide adequate supplies of appropriate personal protective equipment (PPE)
- ensure that staffing patterns take into account the toll that patient care can exact on frontline clinicians
- distribute burdens equitably among providers in situations when individual physicians or other health care personnel *should not* put themselves at risk
- have in place fair and transparent mechanisms for responding to individuals who decline to treat on the basis of risk. (Compare Opinion 8.7, "Routine Universal Immunization of Physicians.")

Equally, institutions support staff by gratefully acknowledging the contributions all personnel make to the operation of the institution and providing psychosocial support for staff.

Professional Organizations

So too physicians and other health care professionals should be able to rely on their professional organizations to advocate for appropriate support of the health care workforce, as in fact several organizations have done over the course of the COVID-19 pandemic. In March 2020, the American Medical Association, American Hospital Association, and American Nurses Association, for example, jointly argued vigorously for and helped secure use of the Defense Production Act (DPA) to provide PPE. The American College of Physicians similarly urged use of the DPA to address the shortage of PPE. Physicians for Human Rights led a coalition of organizations that called on the National Governors Association to urge governors to implement mandatory standards for protecting health workers during the pandemic.

The AMA further advocated for opening visa processing for international physicians to help address workforce issues, and secured financial support for physician practices under the Provider Relief Fund of the American Rescue Plan Act.

Public Policy

As noted, the *Code* originally delineated reciprocal obligations among physicians, patients, and society. Such obligations on the part of communities and public policymakers should be acknowledged as among the main factors that "contour the duty to treat" [1]. More specifically, it is argued,

> in preparation for epidemics communities should: 1) take all reasonable precautions to prevent illness among health care workers and their families; 2) provide for the care of those who do become ill; 3) reduce or eliminate malpractice threats for those working in high-risk emergency situations; and 4) provide reliable compensation for the families of those who die while fulfilling this duty [1].

In the face of the failure on the part of health care institutions and public agencies to ensure that essential resources have been in place to reduce risk and lessen the burdens for individuals of taking on the inevitable risk that remains, it is understandable that physicians and other health care professionals may resent the expectation that they will unhesitatingly put themselves at risk. At least one scholar has forcefully argued that, in the case of COVID-19, celebrations of medical heroism were overwhelmingly insensitive to the fact such heroism was the "direct, avoidable consequence" of institutional and public policy decisions that left the health care system unprepared and transferred the burden of responding to the pandemic to individual health care professionals [8].

ACKNOWLEDGING THE DUTY TO TREAT: SOLIDARITY

In the end, seeing the duty to treat as simply a matter of physicians' altruistic dedication to patients forecloses considerations that can rightly condition the duty in individual circumstances. As Opinion 8.3 observes, providing care for individual patients in immediate need is not physicians only obligation in a public health crisis. They equally have an obligation to be part of ensuring that care can be provided in the future. Equating duty to treat with altruism "makes invisible moral conflicts between the various parties to whom a person may owe care, and interferes with the need of healthcare professionals to understand that they must take all possible measures consistent with the social need for a functioning healthcare system to protect themselves in an epidemic" [7].

Further, such a view not only elides institutional and societal obligations but misrepresents how the duty actually plays out in contemporary health care settings. The risks posed by pandemic disease are distributed across the health care workforce, not uniquely borne by individuals, let alone by individual physicians. Ultimately, the risk refused by one will be borne by someone else, someone who is more often than not a colleague [2,7]. From this perspective, accepting the duty to treat is an obligation physicians owe to fellow health care personnel as much as to patients or to society.

AN ENDURING PROFESSIONAL RESPONSIBILITY

Taken together, the foregoing considerations argue that physicians indeed *should* recognize the duty to treat as a fundamental obligation of professional ethics. This is not to argue that the duty is absolute and unconditional. However, as the Preface to Opinions of the Council on Ethical and Judicial Affairs observes, recognizing when circumstances argue against adhering to the letter of one's ethical obligations

> … requires physicians to use skills of ethical discernment and reflection. Physicians are expected to have compelling reasons to deviate from guidance when, in their best judgment, they determine it is ethically appropriate or even necessary to do so.

Decisions to decline a duty to treat during a public health crisis carry consequences well beyond the immediate needs of individual patients. In exercising the required discernment and ethical reflection, physicians should take into account:

- the urgency of patients' medical need and likelihood of benefit
- the nature and magnitude of risks to the physician and others to whom the physician also owes duties of care
- the resources available or reasonably attainable to mitigate risk to patients, themselves and others
- other strategies that could reasonably be implemented to reduce risk, especially for those who are most vulnerable
- the burden declining to treat will impose on fellow health care workers

Physicians who themselves have underlying medical conditions that put them at high risk for severe disease that cannot reasonably be mitigated, or whose practices routinely treat patients at high risk, have a responsibility to protect themselves as well as their patients. But protecting oneself and one's patients carries with it a responsibility to identify and act on opportunities to support colleagues who take on the risk of providing frontline care.

Physicians and other health care workers *should* be able to rely on the institutions within which they work to uphold the organization's responsibility to promote conditions that enable caregivers

to meet the ethical requirements of their professions. So too, physicians and other health care workers *should* be able to trust that public policymakers will make and enforce well-considered decisions to support public health and the health care workforce. When those expectations are not met, physicians have a responsibility to advocate for change [Principles III, IX].

Yet, grounded as it is in physicians' commitment of fidelity to patients, the professional duty to treat ultimately overrides the failure of institutions or society.

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