

OPINION OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS

The following reports were presented by Peter A. Schwartz, MD, Chair:

1. AMENDMENT TO E-9.3.2, “PHYSICIAN RESPONSIBILITIES TO COLLEAGUES WITH ILLNESS, DISABILITY OR IMPAIRMENT”

Opinion; no reference committee hearing

HOUSE ACTION: FILED

INTRODUCTION

At the 2022 Annual Meeting, the American Medical Association House of Delegates adopted the recommendations of Council on Ethical and Judicial Affairs Report 3-A-22, “Amendment to E-9.3.2, “Physician Responsibilities to Colleagues with Illness, Disability or Impairment.” The Council issues this Opinion, which will appear in the next version of AMA PolicyFinder and the next print edition of the *Code of Medical Ethics*.

E-9.3.2 - Physician Responsibilities to Colleagues with Illness, Disability or Impairment

Providing safe, high-quality care is fundamental to physicians’ fiduciary obligation to promote patient welfare. Yet a variety of physical and mental health conditions—including physical disability, medical illness, and substance use—can undermine physicians’ ability to fulfill that obligation. These conditions in turn can put patients at risk, compromise physicians’ relationships with patients, as well as colleagues, and undermine public trust in the profession.

While some conditions may render it impossible for a physician to provide care safely, with appropriate accommodations or treatment many can responsibly continue to practice, or resume practice once those needs have been met. In carrying out their responsibilities to colleagues, patients, and the public, physicians should strive to employ a process that distinguishes conditions that are permanently incompatible with the safe practice of medicine from those that are not and respond accordingly.

As individuals, physicians should:

- (a) Maintain their own physical and mental health, strive for self-awareness, and promote recognition of and resources to address conditions that may cause impairment.
- (b) Seek assistance as needed when continuing to practice is unsafe for patients, in keeping with ethics guidance on physician health and competence.
- (c) Intervene with respect and compassion when a colleague is not able to practice safely. Such intervention should strive to ensure that the colleague is no longer endangering patients and that the individual receive appropriate evaluation and care to treat any impairing conditions.
- (d) Protect the interests of patients by promoting appropriate interventions when a colleague continues to provide unsafe care despite efforts to dissuade them from practice.
- (e) Seek assistance when intervening, in keeping with institutional policies, regulatory requirements, or applicable law.

Collectively, physicians should nurture a respectful, supportive professional culture by:

- (f) Encouraging the development of practice environments that promote collegial mutual support in the interest of patient safety.

- (g) Encouraging development of inclusive training standards that enable individuals with disabilities to enter the profession and have safe, successful careers.
- (h) Eliminating stigma within the profession regarding illness and disability.
- (i) Advocating for supportive services, including physician health programs, and accommodations to enable physicians and physicians-in-training who require assistance to provide safe, effective care.
- (j) Advocating for respectful and supportive, evidence-based peer review policies and practices to ensure fair, objective, and independent assessment of potential impairment whenever and by whomever assessment is deemed appropriate to ensure patient safety and practice competency. (II)

Preliminary Draft
Pending Policy Numbers

REPORTS OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS

The following reports were presented by Peter A. Schwartz, MD, Chair:

1. AMENDMENT TO OPINION 4.2.7, “ABORTION”

Reference committee hearing: see report of Reference Committee on Amendments to Constitution and Bylaws.

HOUSE ACTION: RECOMMENDATIONS ADOPTED
REMAINDER OF REPORT FILED
See Policy TBD

Current guidance on abortion in Opinion 4.2.7 of the AMA *Code of Medical Ethics* was issued in 1977 in the context of the U.S. Supreme Court decision in *Roe v. Wade*,¹ which recognized a constitutional right to abortion. The Court’s recent decision in *Dobbs v. Jackson Women’s Health Organization*² overturning *Roe* and returning debate about abortion to the states has significantly altered the landscape for patients and their physicians.

As the American Medical Association immediately [noted](#), *Dobbs*:

overturn[s] nearly a half century of precedent protecting patients’ right to critical reproductive health care—representing an egregious allowance of government intrusion into the medical examination room, a direct attack on the practice of medicine and the patient-physician relationship, and a brazen violation of patients’ rights to evidence-based reproductive health services.

The AMA joined the American College of Obstetricians and Gynecologists and more than 70 other professional medical associations in [condemning](#) the unacceptable effects *Dobbs* will have on access to safe, accepted, essential reproductive health services; the privacy and integrity of patient-physician relationships; and indeed, the safety of patients and physicians.

Guidance throughout the *Code* underscores physicians’ duty of fidelity to patients and to promote access to care, as well as responsibility to support informed decision making in keeping with patients’ individual goals and preferences as autonomous moral agents. The *Code* likewise prohibits physicians acting as agents of government entities in conflict with their duties to patients. At the same time, the *Code* acknowledges that physicians too are moral agents as individuals, whose deeply held personal beliefs may at times conflict with the expectations held of them as medical professionals, and offers guidance to help physicians navigate an ethically acceptable path forward in the face of diverging commitments.

Finally, the *Code* [acknowledges](#) that although deeply intertwined, law and the ethical commitments of the profession do not always align:

In some cases, the law mandates conduct that is ethically unacceptable. When physicians believe a law violates ethical values or is unjust they should work to change in law. In exceptional circumstances of unjust laws, ethical responsibilities should supersede legal duties.

When the letter of the law would foreclose urgently needed care physicians must have latitude to act in accord with their best professional judgement.

RECOMMENDATION

With all of the foregoing considerations in mind, the Council on Ethical and Judicial Affairs recommends that Opinion 4.2.7, “Abortion,” be amended as follows and the remainder of this report be filed:

Abortion is a safe and common medical procedure, about which thoughtful individuals hold diverging, yet equally deeply held and well-considered perspectives. Like all health care decisions, a decision to terminate a pregnancy should be made privately within the relationship of trust between patient and physician in keeping with the patient’s unique values and needs and the physician’s best professional judgment.

The *Principles of Medical Ethics* of the AMA ~~do not prohibit a physician from performing an abortion permit physicians to perform abortions~~ in keeping with good medical practice ~~under circumstances that do not violate the law.~~

REFERENCES

1. *Roe v. Wade*, 410 U. S. 113 (1973).
2. *Dobbs v. Jackson Women's Health Organization*, 142 S.Ct. 2228.

2. AMENDMENT TO OPINION 10.8, "COLLABORATIVE CARE"

Reference committee hearing: see report of Reference Committee on Amendments to Constitution and Bylaws.

**HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
WITH THE CONCURRENCE OF THE COUNCIL
REMAINDER OF REPORT FILED
See Policy TBD**

Recent years have seen the rise of nonphysician practitioners (e.g., nurse practitioners, physician assistants, midwives) as a growing share of health care providers in the United States. Moreover, nonphysician practitioners have gained increasing autonomy, authorized by state governments (e.g., legislatures and licensing boards) in response to the lobbying from professional associations, as part of an effort to ameliorate provider shortages, and in response to rising health care costs. Expanded autonomy has increased the interactions of independent nonphysician practitioners and physicians in care of patients. Increasingly nonphysician practitioners are seeking advanced training that results in a doctorate degree, such as "Doctor of Nursing." Such terminology sometimes results in misconception or confusion for both patients and physicians about the practitioner's skillset, training, and experience.

The following is an analysis of the ethical concerns centering on issues of transparency and misconception. In recognition of the growing relevance of the issue, the Council brings this analysis on its own initiative, offering an amendment to the AMA *Code of Medical Ethics* Opinion 10.8 Collaborative Care.

DESCRIPTION OF NONPHYSICIAN PRACTITIONERS

The term "nonphysician practitioners" denotes a broad range of professionals including nurse practitioners, physician assistants, midwives, doulas, pharmacists, and physical therapists. There are "multiple pathways" for one to become a nonphysician practitioner, the most common is a nurse earning a "master's degree or doctoral degree in nursing" after initial completion of a bachelor's degree [1]. However, the skill sets and experience of nonphysician practitioners are not the same as those of physicians. Hence, when a nonphysician practitioner identifies themselves as "Doctor" consistent with the degree they received, it may create confusion and be misleading to patients and other practitioners.

PATIENT CONFUSION AND MISCONCEPTION

Patient confusion and misconception about provider credentials is a significant concern. Data suggest that many patients are not sure who is and who is not a physician. For example, 47% of respondents in one survey indicated they believed optometrists were physicians (10% were unsure), while some 15% believed ophthalmologists are *not* (with 12% being unsure) [2]. Nineteen percent of respondents to the same survey believed nurse practitioners (NPs) to be physicians, although 74% identified them as nonphysicians.

Meanwhile, the range of professional titles of various NPs is wide and the issue is compounded by the fact that many NPs hold doctorate degrees [3]. While the PhD in nursing degree is the oldest and most traditional doctorate in the nursing profession, having its roots in the 1960s and 70s [4], Al-Agba and Bernard note how in "recent years, an explosion of doctorates in various medical professions has made the label of 'doctor' far less clear", a common example being that of the "Doctor of Nursing Practice" (DNP) [3]. The DNP, a professional practice doctorate (distinct from the research-oriented PhD), was first granted in the U.S. in 2001. As of 2020, there are now 348 DNP programs in the U.S. [3]. Critics argue that the rise of DNP programs is not about providing better patient care, but is rather a "political maneuver, designed to appropriate the title of 'doctor' and create a false sense of equivalence between nurse practitioners and physicians in the minds of the public" [3].

The problem of identification has been recognized by some states where NPs with a doctorate are only allowed to be “addressed as ‘doctor’ if the DNP clarifies that he or she is actually an NP” and some jurisdictions require NPs without a doctorate to have special identification that “unambiguously identifies them” [5]. From an ethical standpoint, NPs have a duty as do all health care practitioners, including physicians, to be forthright with patients about their skill sets, education, or training, and to not allow any situation where a misconception is possible. Ambiguous representation of credentials is unethical, because it interferes with the patient’s autonomy, as the patient is not able to execute valid informed consent if they misconstrue the provider. For example, a patient may only want a certain procedure done by a physician and then assent to an NP performing the procedure, under the mistaken belief that the NP is a physician. However, such an assent to the medical procedure is neither a valid *consent* nor an adequately informed *assent*, as the patient’s decision is founded on a flawed basis of key information, i.e., the nature and extent of the practitioner’s skill set, education, and experience.

GUIDANCE IN AMA POLICY AND CODE OF MEDICAL ETHICS

AMA House Policy and the AMA *Code of Medical Ethics* respond to and recognize issues of transparency of credentials and professional identification. However, the *Code* could be modestly amended to offer specific guidance regarding transparency in the context of team-based care involving nonphysician practitioners.

House Policy

[H-405.992](#) – “Doctor as Title,” states:

The AMA encourages state medical societies to oppose any state legislation or regulation that might alter or limit the title ““Doctor,” which persons holding the academic degrees of Doctor of Medicine or Doctor of Osteopathy are entitled to employ.

[D-405.991](#) – “Clarification of the Title “Doctor” in the Hospital Environment,” states:

Our AMA Commissioners will, for the purpose of patient safety, request that The Joint Commission develop and implement standards for an identification system for all hospital facility staff who have direct contact with patients which would require that an identification badge be worn which indicates the individual's name and credentials as appropriate (i.e., MD, DO, RN, LPN, DC, DPM, DDS, etc), to differentiate between those who have achieved a Doctorate, and those with other types of credentials.

[H-405.969](#) – “Definition of a Physician”, states:

... a physician is an individual who has received a “Doctor of Medicine” or a “Doctor of Osteopathic Medicine” degree or an equivalent degree following successful completion of a prescribed course of study from a school of medicine or osteopathic medicine.

AMA policy requires anyone in a hospital environment who has direct contact with a patient who presents himself or herself to the patient as a “doctor,” and who is not a “physician” according to the AMA definition above, must specifically and simultaneously declare themselves a “nonphysician” and define the nature of their doctorate degree.

Code of Medical Ethics

The Code already addresses transparency in context of residents and fellows. [Opinion 9.2.2](#), “Resident & Fellow Physicians’ Involvement in Patient Care,” possesses some language regarding transparency and identification where it states:

When they are involved in patient care, residents and fellows should:

- (a) Interact honestly with patients, including clearly identifying themselves as members of a team that is supervised by the attending physician and clarifying the role they will play in patient care.

In the context of a team-based collaborative care involving nonphysician practitioners, [Opinion 10.8](#), “Collaborative Care” is the most relevant *Code* opinion. It gives guidance on the collaborative team-based setting, where a mix of health professionals provide care. However, Opinion 10.8 lacks guidance on the transparency of identification and credentials, ultimately leaving the *Code* silent on the issue of transparency in the context of team-based collaborative care. Hence, amendment to Opinion 10.8 is warranted.

RECOMMENDATION

In light of the foregoing, the Council on Ethical and Judicial Affairs recommends that Opinion 10.8, “Collaborative Care,” be amended as follows and the remainder of this report be filed:

In health care, teams that collaborate effectively can enhance the quality of care for individual patients. By being prudent stewards and delivering care efficiently, teams also have the potential to expand access to care for populations of patients. Such teams are defined by their dedication to providing patient-centered care, protecting the integrity of the patient-physician relationship, sharing mutual respect and trust, communicating effectively, sharing accountability and responsibility, and upholding common ethical values as team members.

Health care teams often include members of multiple health professions, including physicians, nurse practitioners, physician assistants, pharmacists, physical therapists, and care managers among others. To foster the trust essential to healing relationships between patients and physicians or nonphysician practitioners, all members of the team should be candid about their professional credentials, their experience, and the role they will play in the patient’s care.

An effective team requires the vision and direction of an effective leader. In medicine, this means having a clinical leader who will ensure that the team as a whole functions effectively and facilitates decision-making. Physicians are uniquely situated to serve as clinical leaders. By virtue of their thorough and diverse training, experience, and knowledge, physicians have a distinctive appreciation of the breadth of health issues and treatments that enables them to synthesize the diverse professional perspectives and recommendations of the team into an appropriate, coherent plan of care for the patient.

As clinical leaders within health care teams, physicians individually should:

- (a) Model ethical leadership by:
 - (i) Understanding the range of their own and other team members' skills and expertise and roles in the patient's care
 - (ii) Clearly articulating individual responsibilities and accountability
 - (iii) Encouraging insights from other members and being open to adopting them and
 - (iv) Mastering broad teamwork skills
- (b) Promote core team values of honesty, discipline, creativity, humility and curiosity and commitment to continuous improvement.
- (c) Help clarify expectations to support systematic, transparent decision making.
- (d) Encourage open discussion of ethical and clinical concerns and foster a team culture in which each member’s opinion is heard and considered and team members share accountability for decisions and outcomes.
- (e) Communicate appropriately with the patient and family, ~~and~~ respecting their unique relationship of patient and family as members of the team.
- (f) Assure that all team members are describing their profession and role.

As leaders within health care institutions, physicians individually and collectively should:

- (fg) Advocate for the resources and support health care teams need to collaborate effectively in providing high-quality care for the patients they serve, including education about the principles of effective teamwork and training to build teamwork skills.
- (gh) Encourage their institutions to identify and constructively address barriers to effective collaboration.
- (hi) Promote the development and use of institutional policies and procedures, such as an institutional ethics committee or similar resource, to address constructively conflicts within teams that adversely affect patient care.
- (j) Promote a culture of respect, collegiality and transparency among all health care personnel.

REFERENCES

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3. PANDEMIC ETHICS AND THE DUTY OF CARE

Reference committee hearing: see report of Reference Committee on Amendments to Constitution and Bylaws.

HOUSE ACTION: RECOMMENDATIONS ADOPTED REMAINDER OF REPORT FILED *See Policy TBD*

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 (CEJA) 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.”

At the 2022 Annual Meeting, the Council’s informational report on this matter, CEJA Report 5-A-22, was extracted and referred to Reference Committee on Amendments to Constitution and Bylaws. Testimony acknowledged that the Council has disseminated interpretive materials to help users apply guidance from multiple Opinions in the *AMA Code of Medical Ethics* relating to the duty to treat in crisis situations but felt that additional guidance was nonetheless needed in the *Code* itself. The present report proposes amendments to Opinion 8.3, “Physician Responsibility in Disaster Response and Preparedness.”

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 do not 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 *nonprofessional* 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-interests “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 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, the failure of institutions or society does not in itself absolve physicians of their duty of fidelity to patients and the professional obligation to treat.

RECOMMENDATION

In light of these considerations, the Council on Ethical and Judicial Affairs recommends that Opinion 8.3, "Physician Responsibility in Disaster Response and Preparedness," be amended by addition and deletion as follows and the remainder of this report be filed:

8.3 Physician Responsibility in Disaster Response and Preparedness

Whether at the national, regional, or local level, responses to disasters require extensive involvement from physicians individually and collectively. Because of their commitment to care for the sick and injured, individual physicians have an obligation to provide urgent medical care during disasters. This obligation holds even in the face of greater than usual risks to physicians' own safety, health, or life.

~~However, the physician workforce is not an unlimited resource. Therefore, when providing care in a disaster with its inherent dangers, 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.~~

The duty to treat is foundational to the profession of medicine but is not absolute. The health care work force is not an unlimited resource and must be preserved to ensure that care is available in the future. For their part, physicians have a responsibility to protect themselves, as well as a duty of solidarity to colleagues to share risks and burdens in a public health crisis. So too, health care institutions have responsibilities to support and protect health care professionals and to apportion the risks and benefits of providing care as equitably as possible.

Many physicians owe competing duties of care as medical professionals and as individuals outside their professional roles. In a public health crisis, institutions should provide support to enable physicians to meet compelling personal obligations without undermining the fundamental obligation to patient welfare. In exceptional circumstances, when arrangements to allow the physician to honor both obligations are not feasible, it may be ethically acceptable for a physician to limit participating in care, provided that the institution has made available another mechanism for meeting patients' needs. Institutions should strive to be flexible in supporting physicians in efforts to address such conflicts. The more immediately relevant a physician's clinical expertise is to the urgent needs of the moment and the less that alternative care mechanisms are available, the stronger the professional obligation to provide care despite competing obligations.

With respect to disaster, whether natural or manmade, individual physicians should:

- (a) Take appropriate advance measures, including acquiring and maintaining appropriate knowledge and skills to ensure they are able to provide medical services when needed.

Collectively, physicians should:

- (b) Provide medical expertise and work with others to develop public health policies that:
 - (i) Are designed to improve the effectiveness and availability of medical services during a disaster
 - (ii) Are based on sound science
 - (iii) Are based on respect for patients
- (c) Advocate for and participate in ethically sound research to inform policy decisions.

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4. RESEARCH HANDLING OF DE-IDENTIFIED PATIENT INFORMATION

Informational report; no reference committee hearing.

HOUSE ACTION: FILED

Policy [D-315.969](#) adopted in November 2021 directs the Council on Ethical and Judicial Affairs to “consider re-examining existing guidance relevant to the confidentiality of patient information, striving to preserve the benefits of widespread use of de-identified patient data for purposes of promoting quality improvement, research, and public health while mitigating the risks of re-identification of such data.”

Independently, at its August 2021 meeting the Council concluded that in light of the complex issues arising with the rapid development of data science and increasing research use of large health-related data sets, along with recent changes in the Common Rule governing research with human participants, it would reconsider guidance in Opinion [7.3.7](#), “Safeguards in the Use of DNA Databanks” and would in addition review other existing guidance on confidentiality last updated in 2016 as part of the overall project to modernize the AMA *Code of Medical Ethics*.

This review is ongoing. The Council anticipates submitting its preliminary report to the House of Delegates at the June 2023 Annual Meeting.

Preliminary Draft
Pending Policy Numbers