

AMA Code of Medical Ethics: Guidance in a pandemic

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This article is the first in a series of COVID-19 medical ethics guidance based on the *AMA Code of Medical Ethics*.

The *AMA Code of Medical Ethics* offers foundational guidance for health care professionals and institutions responding to the COVID-19 pandemic in Opinion 8.3, "Physicians' Responsibilities in Disaster Response and Preparedness," and Opinion 11.1.3, "Allocating Limited Health Care Resources."

As its title suggests, Opinion 8.3, sets out physicians' ethical obligations in situations of epidemic, disaster, or terrorism. First and foremost is the obligation to "provide urgent medical care during disasters," an obligation that holds "even in the face of greater than usual risk to physicians' own safety, health or life." Opinion 8.3 recognizes that the physician workforce itself is not an unlimited resource, however. The risks of providing care to individual patients today should be evaluated against the ability to provide care in the future.

Opinion 11.1.3 sets out criteria for allocating limited resources among patients in various contexts, including triage situations—for example, ventilators during a pandemic:

- Urgency of (medical) need
- Likelihood and anticipated duration of benefit
- Change in quality of life

Opinion 11.1.3 further calls on health care professionals and institutions to:

- Give first priority to patients for whom treatment will avoid premature death or extremely poor outcomes
- Use an objective, flexible, transparent mechanism to determine which patients will receive recourse when there are not substantial differences among patients
- Requires that allocation policies be explained both to patients who are denied access to limited resources and to the public

As official policy positions of the AMA, Opinions in the *Code* are of necessity framed broadly, intended to be applicable across a range of settings. The following discussions interpret guidance from across the *Code* to issues that are emerging as the pandemic evolves:

- | Allocating personal protective equipment among health care personnel
- | Responsibilities of leaders of health care teams in the context of pandemic disease
- | Considerations of stewardship in balancing the needs of individual patients and those of the community at large

Protecting health care personnel

Questions about allocating limited resources don't involve only matters of distributing resources among patients, of course. How should health care institutions and their personnel think about distributing personal protective equipment (PPEs) in the face of ongoing shortages?

Although the *Code of Medical Ethics* doesn't speak directly to the question, it can offer insight to help think through an answer. Consider, for example, two key allocation criteria set out in Opinion 11.1.3, "Allocating Limited Health Care Resources": urgency of need and likelihood of benefit.

For decisions about PPEs, "urgency of need" in the first instance might relate to the physician's role in the institution and degree of contact with patients. In a pandemic crisis, physicians and other health care personnel who are on the front lines triaging incoming patients may have more urgent need for, and thus greater claim on, limited stocks of protective gear than others. So might those who have volunteered or been assigned to provide care in isolation wards.

In a 2010 report, the AMA's Council on Ethical and Judicial Affairs drilled down a little deeper in analyzing physicians' obligations to accept immunization. The more transmissible the disease, and the higher the risk of occupational exposure, the more urgent the need for protection. Second order risks that an infected physician might pose to patients and colleagues, or members of their own household or other intimates, should also factor into decisions about access to PPE.

Whether physicians can ethically decline to provide care if PPE is not available depends on several considerations, particularly the anticipated level of risk. In some instances, circumstances unique to the individual physician, or other health care professional, may justify such a refusal—for example, when a physician has underlying health conditions that put them at extremely high risk for a poor outcome should they become infected.

In any situation, when best possible PPE are severely limited or not available, efforts need to be made to find or devise ways to reduce risk to health care personnel to the greatest extent possible.

The benefits of protecting physicians and all health care personnel, especially those who are most immediately at risk by virtue of their service to patients, accrue to the public at large.

Leading the pandemic care “team”

In crisis situations, physicians’ ethical responsibilities to be effective leaders of health care teams may come into sharper focus than ever. Providing the best care one can in the volatile environment of a rapidly evolving pandemic, especially when key resources may be limited, challenges the entire team, but especially the individual looked to as team leader. The *AMA Code of Medical Ethics* articulates key considerations for physician-leaders in Opinion 10.8, “Collaborative Care.”

Physicians’ responsibility to model ethical leadership doesn’t diminish with the pace of work. They must be mindful of their own and other team members’ skills, expertise and roles in patient care and hold the team accountable for fulfilling their individual and collective responsibilities. Ensuring that team members are heard and their views considered is essential to the open discussion of ethical and clinical concerns required for effective teamwork.

As leaders of health care teams, physicians also have responsibilities to advocate for resources and support, as well as to encourage institutions to identify and address barriers to effective collaboration.

In situations of pandemic or disaster, the idea of a health care “team” may encompass more than the care teams of a single institution. The professional community at large may need to function collectively as a “team” in providing care to the social and geographic communities in which they practice. Opinion 11.1.4, “Financial Barriers to Health Care Access,” enjoins all physicians to promote access to care for individual patients, regardless of the patient’s economic means. It encourages physicians in poor communities to turn to colleagues in more prosperous communities for assistance; this implies in turn a reciprocal obligation for colleagues in more prosperous communities to assist within their means.

“Stewardship” in a pandemic

The looming threat of shortages of medications, critical equipment and other supplies makes questions of stewardship tangible and immediate in the context of pandemic. Opinion 11.1.2, “Physician Stewardship of Health Care Resources,” in the *AMA Code of Medical Ethics* sets out key facets of physicians’ obligation to be prudent stewards of the “shared societal resources with which

they are entrusted.”

Opinion 11.1.2 recognizes the primacy of physicians’ ethical obligation to the well-being of individual patients but sets that obligation in the context of physicians’ concurrent duty to promote public health and access to care. Physicians are instructed, as always, to base recommendations and decisions on patients’ medical needs and endorse recommendations that offer reasonable likelihood of meeting patients’ health care goals. But in doing so, Opinion 11.1.2 calls on physicians to “choose the course of action that requires fewer resources when alternative courses of action offer similar likelihood of benefit and degree of anticipated benefit compared to anticipated harm for the individual patient but require different levels of resources.”

Opinion 11.1.2 also recognizes that individual physicians alone can’t and shouldn’t be expected to address “systemic challenges of wisely managing health care resources,” and provides guidance for the profession as a whole, and health care institutions, to “create conditions that make it possible for individual physicians to be prudent stewards.”

The obligation of stewardship requires physicians to strike an ethically justifiable balance between the specific needs of their individual patients and the global needs of the community of patients overall. Under conditions of a public health crisis, the obligation of stewardship may require physicians to consider alternative, less-preferred therapies for some individuals when there may be new critical public need for the same therapies. The goal is to minimize harm both to one’s own population of patients and to the community of patients. As Opinion 1.1.2, “Prospective Patients,” notes, physicians have an “ethical obligation to provide care in cases of medical emergency. Physicians must also uphold ethical responsibilities not to discriminate against a prospective patient on the basis of race, gender, sexual orientation or gender identity, or other personal or social characteristics that are not clinically relevant to the individual’s care.”

Pressing existing therapies into new uses in pandemics, whether drugs or devices, is fundamentally a form of innovation, and thus should be informed by the guidance of Opinion 1.2.11, “Ethically Sound Innovation in Medical Practice.” Opinion 1.2.11 provides that physicians who adopt innovative practices should:

- | Do so on the basis of sound scientific evidence and appropriate clinical expertise
- | Seek input from colleagues or other medical professionals in advance or as early as possible in the course of innovation
- | Minimize risks to individual patients and maximize the likelihood of application and benefit for populations of patients

Importantly, innovators should also be sensitive to the costs, financial or otherwise, of their innovation.