

Access and health equity during a pandemic

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The commitment to fair access to care runs throughout the *AMA Code of Medical Ethics*. Principle IX enjoins physicians to “support access to care for all people.” Opinion 1.1.2, “Prospective Patients,” instructs physicians to uphold ethical responsibilities not to discriminate on the basis of “personal or social characteristics that are not clinically relevant to the individual’s care,” as does Opinion 8.5, “Disparities in Health Care.” Both Opinion 11.1.1, “Defining Basic Health Care,” and Opinion 11.1.4, “Financial Barriers to Health Care Access,” define health care as “a fundamental human good” that entails obligations to promote access to care on the part of individual physicians, the medical profession, and society at large.

The crisis conditions of a pandemic can acutely challenge this commitment, especially for patient populations already minoritized or marginalized with respect to access to care. The extraordinary burden on staffing created by a pandemic and shortages of critical clinical resources can undermine entry into the system of care itself, and, for patients who do gain entry, access to life-sustaining resources.

Emergency departments can quickly be overwhelmed by seriously ill patients suspected to be infected, along with the insured “worried well” who fear they might be but aren’t ill yet, relegating uninsured patients who are seeking primary care services to the end of the queue. Extended waiting times, especially in crowded waiting rooms, increase their risk of exposure and infection beyond the problem that brought them to the ED. For many of these patients, receiving care in other forms, such as telemedicine, realistically won’t be an option for nonclinical reasons, such as lack of access to Broadband.

When shortages of critical resources can’t be overcome in the near term and acceptable workarounds can’t be engineered, excruciating decisions will have to be made about who will have access to what care. This too can further disadvantage identifiable populations of patients.

Procedurally fair criteria for allocating limited resources base decisions first on medical need and likelihood of benefit (and then, when criteria of medical need do not substantially distinguish among patients), an objective mechanism like a lottery.

Decisions to allocate scarce resources should *not* be based on non-medical criteria, such as judgments about a patient’s “social worth,” or the degree to which the patient may have contributed to

illness. Although some include “quality of life,” with treatment and without, among criteria for distinguishing among patients, the *Code* sees this as fundamentally a subjective judgment and thus problematic as a criterion for allocating scarce resources. Opinion 5.1, “Advance Care Planning,” understands that quality of life can only be defined by the patient; it is not a judgment that can meaningfully be made by health care professionals.

Yet no matter how objective and fair the criteria used, allocation decisions necessarily privilege some patients by granting them access to scarce resources and disadvantage others by denying them access to those same resources. When comorbidities complicate assessment of medical need and likelihood of benefit, the dilemma becomes acute for patients who are members of historically marginalized populations or are otherwise disadvantaged with respect to health care services even under normal conditions. These are the very patients who in many cases suffer from comorbidities, or whose comorbidities may be most problematic clinically, *because* they have lacked access to care.

The population of “structurally disadvantaged” patients is heterogeneous. It can include not only patients from communities of color, but also patients with chronic (especially chronically under or untreated) medical conditions, persons with disabilities, and patients with socially stigmatized conditions. The challenge for decision making in a pandemic is not to exacerbate existing marginalization.

In keeping with Opinion 11.1.1, crisis standards of care should be sensitive to the problem of disproportionate effect. Granular criteria for decisions should attend not only to the existence of comorbidity, but also to the need to assess the implications of factoring comorbidities into decisions as well so as to minimize, to the greatest extent possible, the likelihood that decisions will have discriminatory impact.

Additional ethics guidance in a pandemic

The AMA offers an overview of foundational guidance regarding medical ethics for health care professionals and institutions responding to the COVID-19 pandemic.