

8.3 Physicians' Responsibilities in Disaster Response & 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.

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.

AMA Principles of Medical Ethics: V,VI,VII,VIII

Background report(s):

CEJA Report 6-A-04 Physician obligation in disaster preparedness & response

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 6 - A-04

Subject: Physician Obligation in Disaster Preparedness and Response

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Referred to: Reference Committee on Amendments to Constitution and Bylaws
(Mary W. Geda, MD, Chair)

1 The terrorist attacks of 2001 were a reminder that individual and collective safety cannot be taken
2 for granted. Since then, physicians, alongside public health professionals and other health care
3 professionals as well as non-health care personnel, have been developing plans to enhance the
4 protection of public health and the provision of medical care in response to various threats,
5 including acts of terrorism or bioterrorism. Included in those plans are strategies to attend to large
6 numbers of victims and help prevent greater harm to even larger populations.¹

7
8 It is important to recognize that unique responsibilities beyond planning rest on the shoulders of the
9 medical profession. Indeed, irrespective of the cause of harm, physicians are needed to care for
10 victims. In some instances, this will require individual physicians to place their health or their lives
11 at risk. Many physicians demonstrated their sense of duty and courage by participating in the
12 rescue efforts that followed the events of September 11, 2001, and many were involved in the
13 public health efforts that arose from the anthrax contamination. These and other recent events,
14 such as the debate regarding smallpox vaccination of front-line responders and the SARS epidemic,
15 offer the medical profession and each of its members a unique opportunity to reflect anew on
16 ethical responsibilities that arise in the face of adversity.

17 18 A BRIEF HISTORY OF ETHICAL OBLIGATIONS IN THE FACE OF RISKS

19
20 Prior to the events of 2001, the most recent profession-wide debate regarding a duty to treat despite
21 personal risks arose when there was limited understanding of HIV transmission. Those who
22 believed there was a duty to treat appeared to rely in part on historical evidence of the role
23 physicians had played during epidemics. However, some historians remained cautious in making
24 any claim that such a duty existed.^{2,3} In fact, they pointed to many instances when physicians had
25 fled in times of the plague,⁴ and also showed that physicians who had provided care during
26 epidemics had done so not out of a sense of professional obligation, but either because of religious
27 doctrines, because it was lucrative, or because it could result in fame.

* Reports of the Council on Ethical and Judicial Affairs are assigned to the reference committee on Constitution and Bylaws. They may be adopted, not adopted, or referred. A report may not be amended, except to clarify the meaning of the report and only with the concurrence of the Council.

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1 By the time standards of medical ethics became codified, starting with the 1803 code developed by
2 Thomas Percival, a growing sense of the duties owed by professionals had developed. In this vein,
3 the AMA's 1847 code stated that: "When pestilence prevails, it is [physicians'] duty to face the
4 danger, and to continue their labors for the alleviation of the suffering, even at the jeopardy of their
5 own lives." This clear mandate may have been moderated by the introduction of a separate notion
6 that physicians should be free to choose whom to serve in later editions of the code. However, the
7 AIDS epidemic led to a strong reiteration of the obligation to treat.

8
9 Much of the historical analysis regarding physicians' obligation to treat despite personal risk has
10 focused on the treatment of infectious diseases. However, threats to personal safety, health, or life
11 come in many different forms, for example when a natural disaster strikes or during armed
12 conflicts. Along the spectrum of threats, all physicians are confronted with the same question:
13 whether the care needed by a patient or a group of patients calls for the assumption of personal risk.

14 15 ETHICS OF THE MEDICAL PROFESSION

16
17 The AMA's *Principles of Medical Ethics* recognize that many situations in medical care call for a
18 delicate balancing. In the context of a physician's general obligations, the preamble notes that: "As
19 a member of this profession, a physician must recognize responsibility to patients, first and
20 foremost, as well as to society, to other health care professionals, and to self." *Principle VIII*
21 emphasizes physicians' obligations to patients in the following way: "A physician shall, when
22 caring for a patient, regard responsibility to the patient as paramount."

23
24 Arguably, the obligation to treat may be counterbalanced by *Principle VI*, which states: "A
25 physician shall, in the provision of appropriate care, except in emergencies, be free to choose
26 whom to serve... and the environment in which to provide medical care." However, several
27 Opinions limit physicians' choice in light of medical need. (See for example, Opinions E-9.06,
28 "Free Choice," E-9.065, "Caring for the Poor," E-8.11 "Neglect of Patient," and E-10.015 "The
29 Patient-Physician Relationship," AMA Policy Database).

30
31 In the context of infectious diseases, two opinions clarify the ethical obligation of physicians to
32 provide medical care to patients infected with HIV or AIDS. Specifically, Opinion E-2.23, "HIV
33 Testing," states that: "It is unethical to deny treatment to HIV-infected individuals because they
34 are HIV seropositive." Opinion E-9.131, "HIV-Infected Patients and Physicians," also states that:
35 "A physician may not ethically refuse to treat a patient whose condition is within the physician's
36 current realm of competence solely because the patient is seropositive for HIV."

37
38 The *Principles* not only consider the role of the individual physician vis-à-vis an individual patient,
39 but also recognize the role of physicians regarding the patient population. Specifically, *Principle*
40 *VII* calls for participation in activities contributing to the improvement of the community and the
41 betterment of public health, and *Principle IX* calls upon physicians to support access to medical
42 care for all people.

43 44 *Emergencies: individual heroism or professional obligation*

45
46 It often appears that responsibilities to provide emergency care arise in the context of an individual
47 patient. However, an epidemic, a large-scale disaster, or a bioterrorist attack could result in a

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1 significant portion of the population within a community requiring urgent medical care. Under such
2 extraordinary circumstances, it is possible that a number of physicians would exhibit personal
3 courage and provide medical care in the face of risk. However, would the personal courage of
4 individual physicians be sufficient to assure that availability of medical care would not be
5 compromised?
6

7 Instead of relying on individual heroism, physicians have a professional commitment to assure
8 adequate availability of care. Indeed, professional ethics, as embodied by a code of conduct such
9 as the AMA's, is intended to put forth a uniform standard of conduct for individuals who belong to
10 a profession. When large-scale disaster strikes, physicians individually and collectively should use
11 their knowledge and skills to address medical needs.
12

13 In the context of a threat to the health and safety of a population, the unavailability of health care
14 professionals to provide needed medical care, due not to casualties among them but rather to
15 individuals' refusal to assume personal risk, could be viewed as a serious failure of medical
16 professionalism. Is this view of professional obligation morally justified?
17

18 *Professional obligations in the face of personal risk*
19

20 One leading philosopher in health care argues that relevant expert knowledge gives rise to
21 professional acceptance of "known" risks and that it would be disingenuous to accept the privileges
22 of professional status but not to fulfill the obligations.⁵ For example, firefighters and police
23 officers know of the threats they face and are obligated to provide services in spite of those risks;
24 similarly, risks that are foreseeable from a medical perspective cannot be avoided by physicians.
25

26 Such a perspective may explain in part that the risks of HIV infection needed to be understood
27 before they could be assumed. This could lead to the conclusion that, while physicians faced
28 unknown risks at the time of the 2001 terrorist attacks and acted beyond their professional
29 obligations, similar conduct is now becoming part of the professional commitment. In this regard,
30 Alexander and Wynia have shown that physicians who felt that they were well "prepared to play a
31 role in responding to a bioterror attack [were more] willing to work under conditions of personal
32 risk."⁶
33

34 Another compelling justification for a professional commitment in providing medical care in the
35 face of personal risk can be derived from four general factors that give rise to a widely
36 acknowledged moral obligation to render aid.⁷ First is the degree of need: the greater the need, the
37 greater the obligation to assist. This is well recognized in medicine, as expressed in *Principle VI* of
38 the AMA's *Principles of Medical Ethics*, which allows physicians to choose whom to serve, except
39 in emergencies. Next comes the notion of proximity. This can refer to spatial proximity, such that
40 physicians closest to a disaster site have a greater obligation of offering their services than those far
41 from it. Proximity also can be understood as a function of knowledge, such that those with
42 knowledge of a threat have greater obligations to act than those who are ignorant of it. Closely
43 related is the notion of capability. A lifeguard, even if not on duty, has a greater obligation than the
44 occasional swimmer to assist in the rescue of a drowning person. Similarly, there may be other
45 health care professionals available to assist victims, but few would possess the full medical
46 knowledge and skills held by physicians. Finally, it becomes clear that the obligation to provide
47 assistance becomes greater as the possible sources of aid diminish. In this regard, physicians need

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1 not be victims' first providers of care, but often times they will be needed when other providers
2 cannot adequately treat victims. Altogether, these four factors justify a strong professional
3 commitment to providing services to victims in need of medical care despite risk to the provider.
4

5 *Limitations to the duty to treat*
6

7 An obligation to treat need not be absolute. To the extent that reasonable steps can be taken to
8 protect oneself, it is important that physicians avail themselves of such measures. In the context of
9 infectious diseases, vaccination has played a significant role to minimize risk, along with universal
10 precautions. However, instances where individuals fail or refuse to avail themselves, outside
11 appropriate guidelines, of protective measures may be problematic. For example, if a large number
12 of physicians refused certain vaccinations and if they subsequently claimed that they were
13 unwilling to care for infected patients, a considerable burden would likely be placed upon
14 vaccinated physicians.
15

16 Another limitation may exist to the obligation to treat, but needs to be carefully circumscribed.
17 Physicians should not be expected to place themselves at greater risk than the benefit they can
18 provide. Indeed, if the nature of the risk is so lethal that there is little likelihood that a physician
19 can provide care to more than a single patient, then limiting the number of exposed physicians at
20 the onset of an event may be necessary to ensure that a sufficient number remains available to treat
21 patients who can reasonably be expected to survive beyond the acute event.
22

23 To address these various possibilities, sound preparedness strategies need to be established through
24 broad physician consultation. This could lead to the pre-identification of teams of volunteers
25 willing to accept greater risk. These teams could receive specialized training to respond to specific
26 threats instead of each and every physician being expected to possess the necessary knowledge and
27 willingness to respond to any and every threat. Additionally, as the focal points of preparedness,
28 volunteer teams could be offered due compensation for their training, as well as their assumption of
29 risks. Other physicians' responsibilities would become more clearly defined, namely to refer
30 patients knowledgeable according to the nature of the threat.
31

32 Although such strategies would not eliminate all risk to individual physicians under all
33 circumstances, they could help limit undue risk, and assure coordinated, effective and prompt
34 responses. These strategies also could facilitate the education of patient populations regarding the
35 appropriate actions to take according to various threats. In turn, this could help establish realistic
36 societal expectations toward physicians and other health care professionals, alleviate unnecessary
37 confusion or fear, and ultimately help minimize morbidity and mortality.
38

39 Another important dimension to consider as planning efforts move forward is the legal
40 environment in which medical care is provided. Specifically, the medical profession should
41 advocate for the establishment of legal protections that facilitate the provision of medical care by
42 all available and specifically trained physicians, expanding upon laws that protect physicians
43 against liability in special circumstances.
44

45 **CONCLUSION**
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1 Preparedness to the threat of epidemics, disasters or terrorism requires physicians to express a
2 renewed commitment to the ethical foundation of the practice of medicine. Indeed, when the
3 health of large populations is threatened, society should expect that the medical profession will be
4 prepared to provide medical care in a cohesive and comprehensive manner. To accomplish this
5 goal, the obligation to provide care must reside not only with individual physicians, but with the
6 profession as a whole.

7
8 **RECOMMENDATIONS**

9
10 The Council recommends that the following be adopted and the remainder of this report be filed:

11
12 National, regional, and local responses to epidemics, terrorist attacks, and other disasters
13 require extensive involvement of physicians. Because of their commitment to care for the sick
14 and injured, individual physicians have an obligation to provide urgent medical care during
15 disasters. This ethical obligation holds even in the face of greater than usual risks to their own
16 safety, health or life. The physician workforce, however, is not an unlimited resource;
17 therefore, when participating in disaster responses, physicians should balance immediate
18 benefits to individual patients with ability to care for patients in the future.

19
20 In preparing for epidemics, terrorist attacks, and other disasters, physicians as a profession
21 must provide medical expertise and work with others to develop public health policies that are
22 designed to improve the effectiveness and availability of medical care during such events.
23 These policies must be based on sound science and respect for patients. Physicians also must
24 advocate for and, when appropriate, participate in the conduct of ethically sound biomedical
25 research to inform these policy decisions. Moreover, individual physicians should take
26 appropriate advance measures to ensure their ability to provide medical services at the time of
27 disasters, including the acquisition and maintenance of relevant knowledge. (New HOD/CEJA
28 Policy)

Fiscal Note: less than \$500.00

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- ² Fox DM. The History of Responses to Epidemic Disease in the United States since the 18th Century. *Mount Sinai J Med*. 1989; 56;223-229.
- ³ Fox DM. The Politics of Physicians' Responsibility in Epidemics: A Note on History. *Hastings Center Report*. 1988;vol (issue):5-9.
- ⁴ Zuger A, Miles S. Physicians, AIDS, and Occupational Risk: Historic Traditions and Ethical Obligations. *JAMA*. 1987;258;1924-1928 see reference 15
- ⁵ Daniels N. Duty to Treat or Right to Refuse? *Hastings Center Report*. March-April 1991: 36-46.
- ⁶ Alexander GC and Wynia MK. Ready and Willing? Physicians' Sense of Preparedness for Bioterrorism. *Health Affairs*. 2003; 22;189-197.
- ⁷ This analysis is adapted from a presentation by Chalmers Clark, visiting scholar at the Institute for Ethics, which refers to the work of various commentators on the case of Kitty Genovese who died in 1964, as more than 30 people heard her being stabbed. If this analysis is retained, appropriate references will be provided in the next draft.

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