

Subject: Pandemic Ethics and the Duty of Care

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Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Policy D-130.960, “Pandemic Ethics and the Duty of Care,” adopted by the American Medical
2 Association (AMA) House of Delegates in June 2021, asks the Council on Ethical and Judicial
3 Affairs (CEJA) to “reconsider its guidance on pandemics, disaster response and preparedness in
4 terms of the limits of professional duty of individual physicians, especially in light of the unique
5 dangers posed to physicians, their families and colleagues during the COVID-19 global pandemic.”
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7 At the 2022 Annual Meeting, the Council’s informational report on this matter, CEJA Report 5-A-
8 22, was extracted and referred to Reference Committee on Amendments to Constitution and
9 Bylaws. Testimony acknowledged that the Council has disseminated interpretive materials to help
10 users apply guidance from multiple Opinions in the AMA *Code of Medical Ethics* relating to the
11 duty to treat in crisis situations but felt that additional guidance was nonetheless needed in the
12 *Code* itself. The present report proposes amendments to Opinion 8.3, “Physician Responsibility in
13 Disaster Response and Preparedness.”
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15 A CONTESTED DUTY

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17 As several scholars have noted, the idea that physicians have a professional duty to treat has waxed
18 and waned historically, at least in the context of infectious disease [1,2,3]. Many physicians fled
19 the Black Death; those who remained did so out of religious devotion, or because they were enticed
20 by remuneration from civic leaders [1]. Even in the early years of the AIDS epidemic, physicians
21 contested whether they had a responsibility to put themselves at risk for what was then a lethal and
22 poorly understood disease [3]. Yet the inaugural edition of the AMA *Code of Medical Ethics* in
23 1847 codified a clear expectation that physicians would accept risk:
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25 When pestilence prevails, it is [physicians’] duty to face the danger, and to continue their
26 labors for the alleviation of suffering, even at the jeopardy of their own lives [[1847 Code](#), p.
27 105].
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29 That same sensibility informs AMA’s [Declaration of Professional Responsibility](#) when it calls on
30 physicians to “apply our knowledge and skills when needed, though it may put us at risk.” And it is
31 embedded in current guidance in the *Code*. Based on physicians’ commitment of fidelity to
32 patients, [Opinion 8.3](#), “Physicians’ Responsibilities in Disaster Response and Preparedness,”
33 enjoins a duty to treat. This opinion provides that “individual physicians have an obligation to
34 provide urgent medical care during disasters . . . even in the face of greater than usual risks to
35 physicians’ own safety, health, or life.” The *Code* is clear that this obligation isn’t absolute,

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1 however. Opinion 8.3 qualifies the responsibility when it notes that "physicians also have an
2 obligation to evaluate the risks of providing care to individual patients versus the need to be
3 available to provide care in the future."

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

7 8 INTERPRETING ETHICS GUIDANCE

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

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15 Drawing particularly on guidance in [Opinion 1.1.2](#), "Prospective Patients," and—in keeping with
16 Opinion 8.3, taking physicians' expertise and availability as itself a health care resource—[Opinion](#)
17 [11.1.3](#), "Allocating Limited Health Care Resources," as well as [Opinion 8.7](#), "Routine Universal
18 Immunization of Physicians," these analyses offer key criteria for assessing the strength of the duty
19 to treat:

- 20
- 21 • urgency of medical need
- 22 • risk to other patients or staff in a physician's practice
- 23 • risk to the physician
- 24 • likelihood of occurrence and magnitude of risk
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26 To these criteria should be added likelihood of benefit—that is, physicians should not be obligated
27 to put themselves at significant risk when patients are not likely to benefit from care [2]. Although
28 the *Code* does not link the question specifically to situations of infectious disease or risk to
29 physicians, it supports this position. [Opinion 5.5](#), "Medically Ineffective Interventions," provides
30 that physicians are not obligated to provide care that, in their considered professional judgment,
31 will not provide the intended clinical benefit or achieve the patient's goals for care.

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

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

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

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 10 Although the *Code* acknowledges that physicians indeed have lives as moral agents outside
 11 medicine ([Opinion 1.1.7](#), “Physician Exercise of Conscience”), it does not reflect as deeply as it
 12 might about the nature of competing personal obligations or how to balance the professional and
 13 the personal. In much the same way as understanding the duty to treat as the responsibility of a
 14 single profession, restricting analysis to a tension between altruism and physicians’ individual self-
 15 interests “fails to capture the real moral dilemmas faced by health care workers in an infectious
 16 epidemic” [7].

17 18 SUPPORTING THE HEALTH CARE WORKFORCE

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

23
 24 Pandemic disease doesn’t respect conceptual boundaries between the professional and the personal,
 25 the individual and the institutional. Nor does it respect the borders of communities or catchment
 26 areas. In situations of pandemic disease, “the question is one of a social distribution of a
 27 biologically given risk within the workplace and society at large” [7].

28 29 *Health Care Institutions*

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

33
 34 ... organizations, as well as individuals, can be virtuous. A virtuous organization encourages
 35 and nurtures the virtuous behavior of the individuals within it. At the very least, the virtuous
 36 institution avoids creating unnecessary barriers to the virtuous behavior of individuals [2].

37
 38 The *Code* is not entirely insensitive to the ethics of health care institutions. It touches on
 39 institutions’ responsibility to the communities they serve ([Opinion 11.2.6](#), “Mergers between
 40 Secular and Religiously Affiliated Health Care Institutions”) and the needs of physicians and other
 41 health care personnel who staff them (Opinions [11.1.2](#), “Physician Stewardship of Health Care
 42 Resources,” and [11.2.1](#), “Professionalism in Health Care Systems). Health care facilities and
 43 institutions are the locus within which the practice of today’s complex health care takes place. As
 44 such, institutions—notably nonprofit institutions—too have duties,

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 46 ... fidelity to patients, service to patients, ensuring that the care is high quality and provided “in
 47 an effective and ethically appropriate manner”; service to the community the hospital serves,
 48 deploying hospital resources “in ways that enhance the health and quality of life” of the
 49 community; and institutional stewardship [[CEJA 2-A-18](#)].

1 Analyses posted to the AMA’s COVID-19 Resource Center look to this guidance to examine
2 institutional obligations to [protect health care personnel](#) and to respect physicians who voice
3 concern when institutional [policies and practices](#) impinge on clinicians’ ability to fulfill their
4 ethical duties as health care professionals.

5
6 Although existing guidance does not explicitly set out institutional responsibility to provide
7 appropriate resources and strategies to mitigate risk for health care personnel, it does support such
8 a duty. The obligation to be responsible stewards of resources falls on health care institutions as
9 well as individuals. To the extent that health care professionals themselves are an essential and
10 irreplaceable resource for meeting patient and community needs, institutions have an ethical duty
11 to protect the workforce (independent of occupational health and safety regulation). On this view,
12 institutions discharge their obligations to the workforce when, for example, they:

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- 14 • support robust patient safety and infection control practices
- 15 • make immunization readily available to health care personnel
- 16 • provide adequate supplies of appropriate personal protective equipment (PPE)
- 17 • ensure that staffing patterns take into account the toll that patient care can exact on
18 frontline clinicians
- 19 • distribute burdens equitably among providers in situations when individual physicians or
20 other health care personnel *should not* put themselves at risk
- 21 • have in place fair and transparent mechanisms for responding to individuals who decline to
22 treat on the basis of risk. (Compare Opinion 8.7, “Routine Universal Immunization of
23 Physicians.”)
- 24

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

27 *Professional Organizations*

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29
30 So too physicians and other health care professionals should be able to rely on their professional
31 organizations to advocate for appropriate support of the health care workforce, as in fact several
32 [organizations](#) have done over the course of the COVID-19 pandemic. In March 2020, the American
33 Medical Association, American Hospital Association, and American Nurses Association, for
34 example, jointly argued vigorously for and helped secure use of the Defense Production Act (DPA)
35 to [provide PPE](#). The [American College of Physicians](#) similarly urged use of the DPA to address the
36 shortage of PPE. [Physicians for Human Rights](#) led a coalition of organizations that called on the
37 National Governors Association to urge governors to implement mandatory standards for
38 protecting health workers during the pandemic.

39
40 The AMA further advocated for opening [visa processing](#) for international physicians to help
41 address workforce issues, and secured [financial support](#) for physician practices under the Provider
42 Relief Fund of the American Rescue Plan Act.

43 *Public Policy*

44
45
46 As noted, the *Code* originally delineated reciprocal obligations among physicians, patients, and
47 society. Such obligations on the part of communities and public policymakers should be
48 acknowledged as among the main factors that “contour the duty to treat” [1]. More specifically, it
49 is argued,

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

6
 7 In the face of the failure on the part of health care institutions and public agencies to ensure that
 8 essential resources have been in place to reduce risk and lessen the burdens for individuals of
 9 taking on the inevitable risk that remains, it is understandable that physicians and other health care
 10 professionals may resent the expectation that they will unhesitatingly put themselves at risk. At
 11 least one scholar has forcefully argued that, in the case of COVID-19, celebrations of medical
 12 heroism were overwhelmingly insensitive to the fact such heroism was the “direct, avoidable
 13 consequence” of institutional and public policy decisions that left the health care system
 14 unprepared and transferred the burden of responding to the pandemic to individual health care
 15 professionals [8].

16 17 ACKNOWLEDGING THE DUTY TO TREAT: SOLIDARITY

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

27
 28 Further, such a view not only elides institutional and societal obligations but misrepresents how the
 29 duty actually plays out in contemporary health care settings. The risks posed by pandemic disease
 30 are distributed across the health care workforce, not uniquely borne by individuals, let alone by
 31 individual physicians. Ultimately, the risk refused by one will be borne by someone else, someone
 32 who is more often than not a colleague [2,7]. From this perspective, accepting the duty to treat is an
 33 obligation physicians owe to fellow health care personnel as much as to patients or to society.

34 35 AN ENDURING PROFESSIONAL RESPONSIBILITY

36
 37 Taken together, the foregoing considerations argue that physicians indeed *should* recognize the
 38 duty to treat as a fundamental obligation of professional ethics. This is not to argue that the duty is
 39 absolute and unconditional. However, as the Preface to Opinions of the Council on Ethical and
 40 Judicial Affairs observes, recognizing when circumstances argue against adhering to the letter of
 41 one’s ethical obligations

42
 43 ... requires physicians to use skills of ethical discernment and reflection. Physicians are
 44 expected to have compelling reasons to deviate from guidance when, in their best judgment,
 45 they determine it is ethically appropriate or even necessary to do so.

46
 47 Decisions to decline a duty to treat during a public health crisis carry consequences well beyond
 48 the immediate needs of individual patients. In exercising the required discernment and ethical
 49 reflection, physicians should take into account:

- 50 • the urgency of patients’ medical need and likelihood of benefit
- 51

- 1 • the nature and magnitude of risks to the physician and others to whom the physician also
- 2 owes duties of care
- 3 • the resources available or reasonably attainable to mitigate risk to patients, themselves and
- 4 others
- 5 • other strategies that could reasonably be implemented to reduce risk, especially for those
- 6 who are most vulnerable
- 7 • the burden declining to treat will impose on fellow health care workers

8
9 Physicians who themselves have underlying medical conditions that put them at high risk for
10 severe disease that cannot reasonably be mitigated, or whose practices routinely treat patients at
11 high risk, have a responsibility to protect themselves as well as their patients. But protecting
12 oneself and one's patients carries with it a responsibility to identify and act on opportunities to
13 support colleagues who take on the risk of providing frontline care.

14
15 Physicians and other health care workers *should* be able to rely on the institutions within which
16 they work to uphold the organization's responsibility to promote conditions that enable caregivers
17 to meet the ethical requirements of their professions. So too, physicians and other health care
18 workers *should* be able to trust that public policymakers will make and enforce well-considered
19 decisions to support public health and the health care workforce. When those expectations are not
20 met, physicians have a responsibility to advocate for change [[Principles III, IX](#)].

21
22 Yet, the failure of institutions or society does not in itself absolve physicians of their duty of
23 fidelity to patients and the professional obligation to treat.

24 25 RECOMMENDATION

26
27 In light of these considerations, the Council on Ethical and Judicial Affairs recommends that
28 Opinion 8.3, "Physician Responsibility in Disaster Response and Preparedness," be amended by
29 addition and deletion as follows and the remainder of this report be filed:

30 31 8.3 Physician Responsibility in Disaster Response and Preparedness

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

38
39 ~~However, the physician workforce is not an unlimited resource. Therefore, when providing~~
40 ~~care in a disaster with its inherent dangers, physicians also have an obligation to evaluate the~~
41 ~~risks of providing care to individual patients versus the need to be available to provide care in~~
42 ~~the future.~~

43
44 The duty to treat is foundational to the profession of medicine but is not absolute. The health
45 care work force is not an unlimited resource and must be preserved to ensure that care is
46 available in the future. For their part, physicians have a responsibility to protect themselves, as
47 well as a duty of solidarity to colleagues to share risks and burdens in a public health crisis. So
48 too, health care institutions have responsibilities to support and protect health care
49 professionals and to apportion the risks and benefits of providing care as equitably as possible.

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

12
13 With respect to disaster, whether natural or manmade, individual physicians should:

14
15 (a) Take appropriate advance measures, including acquiring and maintaining appropriate
16 knowledge and skills to ensure they are able to provide medical services when needed.

17
18 Collectively, physicians should:

19
20 (b) Provide medical expertise and work with others to develop public health policies that:

21 (i) Are designed to improve the effectiveness and availability of medical services during a
22 disaster

23 (ii) Are based on sound science

24 (iii) Are based on respect for patients

25 (c) Advocate for and participate in ethically sound research to inform policy decisions.
26

27
(Modify HOD/CEJA Policy)

Fiscal Note: Less than \$500

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