

In Harm's Way: AMA Physicians and the Duty to Treat

CHALMERS C. CLARK
Yale University, New Haven, CT, USA

In June 2001, the American Medical Association (AMA) issued a revised and expanded version of the Principles of Medical Ethics (last published in 1980). In light of the new and more comprehensive document, the present essay is geared to consideration of a longstanding tension between physician's autonomy rights and societal obligations in the AMA Code. In particular, it will be argued that a duty to treat overrides AMA autonomy rights in social emergencies, even in cases that involve personal risk to physicians (e.g., bioterrorist attack, HIV infection, SARS). The argument will be made by way of the logic and language of the AMA Code through its history, commentaries, and precedents. It also will be shown that there are substantial reasons to believe that the logic of the Code is sound in morally relevant ways. The essay will conclude with some philosophical proposals suggesting a framework for the duty to render aid and the extension of those duties to physicians facing personal risks.

Keywords: *Social contract, trust, public trust, professional autonomy, duty to treat*

I. INTRODUCTION

The terrorist events surrounding September 11, 2001, the continuing threat of bioterrorism and outbreaks of HIV, West Nile, and SARS, have brought the question of physicians' responsibilities during such large-scale emergencies into sharp relief. Questions are deepened and complicated by the potential risks that physicians would face during such attacks.

Address correspondence to: Chalmers C. Clark, PhD, Department of Philosophy and the Institution for Social and Policy Studies, Yale University, ISPS, 87 Trumbull Street, New Haven, CT 06511, USA. E-mail: ChalmersCC@aol.com

Several years ago, I argued that while Principle VI of the 1980 *AMA Principles of Medical Ethics* establishes strong physician autonomy rights, AMA physicians have obligations to address societal emergencies, autonomy rights notwithstanding (Clark, 1996, pp. 440–443). The crucial phrase from Principle VI informs us that, “except in emergencies” physicians are “free to choose whom to serve and the environment to provide services.” The question I pondered was whether “emergency” was to be construed in narrow terms (bystander cases, emergency room needs) or broad terms (community emergencies, national, international, global, or social). I argued that the logic of the 1980 *Principles of Medical Ethics* could not support a narrow interpretation. However, the point was derived indirectly and a problem of clarity remained.

In June 2001, the AMA issued an expanded and revised version of the *Principles*. The new set of *Principles* strengthens the importance of the patient even further than before and speaks clearly to a physician’s obligations to promote an improved community and work for the betterment of public health. Significantly, however, the wording of Principle VI, which features physician’s autonomy rights, remains substantially unchanged.

The purpose of the present essay is to reconsider the tension between autonomy rights and societal obligations in the *AMA Code*. It will be argued that a duty to treat overrides Principle VI autonomy rights in social emergencies, even in cases that involve personal risk to physicians themselves. Bioterrorism presents a frightfully clear case of such a public emergency.

While it might seem laudable for physicians to place themselves at risk during a public medical crisis, the question we must face is whether it is ethically appropriate to impose a publicly declared duty to do so. The conclusion of this essay will be that it is. The argument will be made by way of the logic and language of the *AMA Code*, its history, commentaries, and precedents. I will then show that there are substantial reasons to believe that the logic of the *Code* is sound in morally relevant ways.

Though dispute over social duties or autonomy rights in the *AMA Code* might seem to renew debate among welfare liberals and libertarians, an attempt is made to reconcile such a tension by appeal to Rawls’ articulation of a principle of majority rule. Finally, the essay will conclude with some philosophical proposals suggesting a framework for the duty to render aid and the extension of those duties to physicians facing personal risks.

II. ANALYSIS OF THE AMA CODE

A. Changes in the Code: 1980 and 2001

While the AMA is publicly perceived as the central voice of the medical profession, the AMA itself accounts for only about 25 percent of U.S. physicians. However, the significance of the AMA to medical ethics comes from a

variety of sources. The AMA is represented in all states and serves thus as an umbrella organization for U.S. physicians. The high social posture of the AMA is recognized world-wide and indeed, the courts increasingly are turning to the AMA *Code of Medical Ethics* for guidance. The *AMA's Code*, first published in 1847, is also the first code of professional ethics. Today, this historically defining document encompasses over 175 ethical issues and sets forth opinions and commentary regarding each of them. The *Code* is not a static set of rules, but a living text that is the result of a deliberative and substantially democratic process designed to emend, review, and reconsider its own standards as matters in medical ethics evolve.¹

The changes made to the American Medical Association's (AMA) *Principles of Medical Ethics* from 1980 to the *Code* of 2001 are carefully detailed on the AMA's web site.² The new set of Principles offers greater emphasis on the "paramount" level of responsibility that physicians have to their patients. In the 1980 Preamble, the phrase "a physician must recognize responsibility, not only to patients, but also to society, to other health professionals, and to self," in 2001 becomes, "a physician must recognize responsibility to *patients first and foremost*, as well as to society, to other health professionals, and to self" (my italics).

There is also a new phrase asserting a strong notion of patient's "rights." In the 1980 version, "respect for human dignity," from Principle I, becomes "respect for human dignity *and rights*" in 2001 (my italics). The new Principles also contain phrases enjoining physicians to "maintain a commitment to medical education" (Principle V) and to contribute to "the improvement of the community and the betterment of public health" (Principle VII).

Beyond these amendments to specific Principles, the 2001 *Code* presents two new principles added to the seven Principles from the 1980 *Code*. The first is Principle VIII: "A physician shall, while caring for a patient, regard responsibility to the patient as paramount." The second is Principle IX: "A physician shall support access to medical care for all people." However, Principle VI, the principle that establishes a physician's autonomy rights, bears no change in substance from the 1980 Principles. The only change in Principle VI occurs in the very last word. "[M]edical service" becomes "medical care." In the 2001 *Code*, Principle VI reads as follows:

VI. A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical care. (*Code of Medical Ethics*, 2002–2003, p. xii)

B. The Persistence of Autonomy Rights: Principle VI

Given the capacious efforts at clarification and development in the 2001 *Code*, it might seem surprising that the autonomy clause of Principle VI

reflects no modification in substance from the 1980 version. Indeed, the provision that “except in emergencies,” a physician is “free to choose whom to serve and the environment to render service” has been continuous in AMA codes of ethics since 1912. The problem, it seems, is that autonomy rights of Principle VI might tend to obscure or even be taken to trump pronouncements in the *Code* that deal with social obligations.³

In general terms, the question thus is whether physicians should be ethically bound to subordinate their autonomy rights when faced with the threat of an acute public medical need. Two distinct matters need to be considered. First is the question of whether societal obligations *ever* trump the autonomy rights of physicians. Second, if they do, does that involve an obligation to assist even at a physician’s peril? As to the first question, the logic of the Principles forces us to answer in the affirmative.

... if we have included an independent reference to societal obligations and allowed that except in emergencies (narrowly construed) such obligations may be overruled in *any case*, then in principle, we have allowed physician autonomy to overrule in *every case*. However, this would render the societal provision altogether pointless. ... it appears that the narrow construal of emergency would arbitrarily foreclose on the responsibility to society clause. Thus, ... a close reading of the AMA document reveals a derivable, although indirect constraint on physician autonomy for at least *some* societal emergencies. (Clark, 1996, p. 442)

While it might be objected that even under this interpretation, a particular physician’s autonomy is free and unconstrained in selecting *which* societal duties are to be undertaken, it should be understood, nonetheless, that such a consideration arises secondary to the more general principle—of the interpretation—that *some* societal duties must trump physician’s autonomy rights, Principle VI terminology notwithstanding.⁴

Thus the point that the narrow interpretation of emergencies arbitrarily forecloses on societal duties is crucial. For once it is allowed that broader societal emergencies sometimes trump physicians’ autonomy rights, the question shifts from “whether or not,” to questions of “when and to what extent.”

C. Final Appeal: Autonomy Rights or “temperate public opinion”?

A precursor to Principle VI of 1980 and 2001 *Code* appears in the 1957 *Code*. In Section 5 of the AMA’s 1957 *Principles of Medical Ethics* we read,

A physician may choose whom he will serve. In an emergency, however, he should render service to the best of his ability. Having undertaken the care of a patient, he may not neglect him; and unless he has been discharged he may discontinue his service only after giving adequate notice. (1958, p. 23)

Historical reference is then made in the 1957 *Code* to the *Code* of 1955 where a decisive phrase is enunciated. In the 1955 *Code*, physicians are enjoined to respond to public needs whenever “temperate public opinion” expects it.

A physician is free to choose whom he will serve. He should, however, respond to any request for his assistance in an emergency or whenever temperate public opinion expects the service....(AMA, 1958, p. 24)

This passage appears sensitive to the rift between narrow and broad interpretations of ‘emergencies’. In fact, it appears to place them on a par. The first sentence above identifies the autonomy standard. The second sentence then speaks of responding to *any* emergency (consistent with narrow or broad sense) or when temperate public opinion expects a response (societal—broad sense). Strikingly, we find the two phrases:

1. “free to chose whom to serve, except in emergencies,” and
2. a physician should respond “whenever temperate public opinion expects the service,” to be jointly continuous in all the AMA codes from 1912 (AMA, 1914, pp. 4–5) until 1955. In the 1912 *Code*, the duty to respond to “temperate public opinion” is earmarked in the index with by the imperative phrase, “Public opinion to command service” (AMA, 1914, p. 27).

It seems reasonable to conclude thus that the writers of the *AMA Code* long believed that temperate public opinion sometimes had sufficient moral and political sway to command physicians into service, autonomy rights notwithstanding. Why this language is “quietly” dropped in the 1980 and 2001 codes, and left to be derived only indirectly, will be discussed later. But if we are satisfied that societal obligations are a persistent feature of the *AMA Code*, and that the meaning of the *Code* implies that societal obligations trump physician autonomy when temperate public opinion expects the service, let us move to consider the case of social emergencies that are likely to put physicians at personal risk when providing service.

D. In Harm's Way: Facing Hazards in Rendering Aid

The issue of personal risk in rendering public service was addressed by the AMA with the publication of the first *AMA Code of Ethics* in 1847. The concern that prompted such considerations was the presence of pestilence and the threat of impending epidemics. In a recent paper, Huber and Wynia illuminate the history of the AMA's apprehensions over the spread of infectious diseases (Huber & Wynia, 2004). Regarding the 1847 *Code* they note, “[t]he third section, addressing physician-public relations, espoused a new

obligation, not found in earlier English iterations” (Huber & Wynia, 2004 p. 7). The new obligation was bold and unequivocal:

When pestilence prevails, it is [physicians'] duty to face the danger, and continue their labors for the alleviation of suffering, even at the jeopardy of their own lives. (Huber & Wynia, 2004 p. 7)

In the 1912 *AMA Code*, not only was regard for personal risk shunned as a reason for physicians to withdraw from service, but so too was regard for financial remuneration in such emergencies (Huber & Wynia, 2004). In an essay by Zuger and Miles, it is argued that in the broad sweep of medical history, from Greece and Rome to the present, no consistent professional tradition has emerged regarding physicians and personal risk. However, since 1847, the AMA's prominent move to embrace such a responsive policy has had sustained effects. In fact it comes as a surprise to many to learn that physicians do not have greater legal obligations as fiduciaries. While physicians might call themselves fiduciaries, such obligations are not generally articulated in law. As Marc Rodwin has pointed out, fiduciary law has been applied to physicians only for very limited purposes (Rodwin, 1993). A sketch of the fiduciary role, however, is addressed below at the end of section 3.1. I indicate how a broad conception of a fiduciary **duty** to treat survives within an implicit social contract that exchanges professional trust for the social bequest of professional autonomy. Zuger and Miles note the significance of the AMA on the duty to treat as follows:

In the history of ethical codes for the medical profession, this statement is unprecedented ... The AMA's strong statement probably owes more to a determination to establish the honor and prestige of the profession than to physicians' actual abilities... Still, the sense of duty formalized by the AMA was sustained ... it becomes far more difficult to find recorded instances of physicians' reluctance to accept the risks that epidemics entailed for them. (Zuger & Miles, 1987, pp. 1924–1928)

With such strong statements focusing on societal obligations of physicians, the question about why such language vanishes after 1957, without argument or explanation, needs to be explored. A further problem, however, is that not only has the language been removed from more recent codes, but a study by Alexander and Wynia warns that “both preparedness and the sense of professional obligation to treat patients during epidemics may be declining” (Alexander & Wynia, 2003, p. 196). The study finds that while 80% of physician respondents reported they would continue to treat patients in the event of an outbreak of an unknown but potentially deadly illness, only 33% reported a willingness to treat if left unvaccinated against a highly contagious and lethal illness like smallpox (Alexander & Wynia, 2003, p. 192).

Huber and Wynia argue that since the language of accepting personal risk was largely crafted as a response to the threat of pestilence, it disappears thus, because the threat no longer seems to be a serious danger. What happened, they write, was that “by the 1950s, the era of massive epidemics was perceived to be ending in America.” (Huber & Wynia, 2004, p. 9) They further note that statements on epidemics were quietly withdrawn in 1977 as “irrelevant ‘historical anachronisms’” (Arras, 1988, p. 14; Huber & Wynia, 2004, p. 12).

Since it wasn't until the 1980s that the rise of the Human Immunodeficiency Virus (HIV) aroused renewed fears of infectious epidemics in the US, this argument is certainly relevant to the problem. Nonetheless, the argument does not apply well in consideration of third world nations. And significantly, the threat of HIV appeared well before the 2001 *Code* was published. Such factors still pose a question as to why the new *Code* didn't return to some version of the earlier language. Indeed, in 1986, in apparent reversal of their own tradition,⁵ the AMA responded to physician fears of HIV infection by issuing a statement that treating HIV-positive patients was required only if the physician was “emotionally able to do so” (Huber & Wynia, 2004, p. 10). Huber and Wynia point out that this statement was widely ridiculed and six months later, it was overridden by a statement asserting that, “A physician may not ethically refuse to treat a patient whose condition is within the physician's current realm of competence solely because the patient is seropositive” (Huber & Wynia, 2004, p. 12).

The language of responding in social emergencies does, however, return to the AMA literature shortly after the devastation of the attacks on the World Trade Center and the Pentagon on September 11, 2001. In December 2001, the House of Delegates of the AMA adopted a “Social Contract with Humanity” that contained a Declaration of Professional Responsibility (AMA, 2002b, pp. 144–145). This declaration, unlike the Principles, is in the form of an oath, and as such “is activated when physicians speak it aloud, affirming [it] together ...” (AMA, 2002b, p. 144). The ethical force of the oath in the Declaration thus comes into being as a “speech act,” similar to acts of promising that are often realized when appropriate verbal utterances become part of the act itself. Like an oath, to promise often implies someone actually saying the words, “I promise.” (Austin, 1962; Searle, 1969). Even so, the oath does bring back the language of personal risk that was present in AMA codes prior to 1980. In the fourth declaration, of the oath's nine duties and obligations, we read,

“We, the members of the world community of physicians, solemnly commit ourselves to:

4. Apply our knowledge and skills when needed, though doing so may put us at risk.” (AMA, 2002b, p. 145)

The Declaration also widens the physician and patient relationship. Specifically, the final sentence of the Declaration's Preamble states, "Humanity is our patient" (AMA, 2002b, p. 145). While the Declaration explicitly mentions humanity as the patient and allows that personal risk does not exempt physicians from service, we are cautioned to remember that the oath "is not a Code of Medical Ethics Opinion, nor does it restate or interpret the *Principles of Medical Ethics*" (AMA, 2002b, p. 144). Even so, this document returns explicit recognition of the longstanding commitment to accepting personal risk as part of a profession that is by its nature designed to combat disease and face a degree of incumbent peril in such an activity (Daniels, 1999). And while we are instructed that the Declaration is not to be used to interpret the *Principles*, it is certainly not to be viewed as irrelevant either.

Perhaps the way to frame the issue is by reference to Aristotle's "reasonable person" standard. The question, so framed, is "What would a conscientious and reasonable physician, with a broad familiarity of the AMA *Code* and its *Principles*, regard as one's duty respecting matters of personal risk?"

With this array of argument and historical record, the seeming gap that Principle VI leaves open to interpret autonomy rights as a trump over societal obligations looks thin and tenuous indeed. It would seem that a pure voluntaristic interpretation of Principle VI could only stand if it was read uncharitably as a "loop hole" amid the other principles and commentary manifest in the broader literature of the *Code*. However, since 1984, even this crabbed way of reading the *Code* has been blocked. In the Preface to the 2002–2003 edition we read,

No one Principle of Medical Ethics can stand alone or be individually applied to a situation. In all instances, it is the overall intent and influence of the Principles of Medical Ethics, which shall measure ethical behavior for the physician. (2002)⁶

Clearly then, we are instructed to avoid considering principles in isolation from the companion principles. Individual cases are to be considered by a balance among the principles. So while the Declaration should not be used to *interpret* the *Principles*, it remains open to consider the Declaration, opinions, and other "externalities" of the *Code*, as a basis to inform our considered judgement regarding the overall intent and meaning of the *Principles* in particular cases. The point, I believe, can be instructively compared to Rawls' conception of "reflective equilibrium." That is, where decisions are explicitly said to be negotiated in a "... process of mutual adjustment of principles and considered judgements ..." (Rawls, 1971, p. 20).

The conception thus is not simply to interpret *Principles* by our considered judgments, but to bring principles and judgements into equilibrium. This is

a state achieved “after a person has weighed various proposed conceptions and he has either revised his judgements to accord with one of them or held fast to his initial convictions. . . .” (Rawls, 1971, p. 48).

Summing up, thus, the background of argument, AMA commentary, and historical precedent leads rather decisively to the conclusion that the case for asserting “pure” Principle VI autonomy rights, during societal medical emergencies, collapses even in cases where there is personal risk to physicians themselves.

III. SOUNDNESS OF THE ARGUMENT

It has been shown that the logic and language of the AMA *Principles*, along with the auxiliary literature, leaves no meaningful doubt that the priority of societal obligations trumps Principle VI autonomy rights in public emergencies. But if our analysis is to be persuasive, we must attend not only to the apparent validity of the argument, but also to its soundness. While the language of the *Code* appears to force our conclusion, we still need to ask if there are independent moral considerations that support the interpretation. In a word, we need to ask why physicians should feel a moral obligation to follow the terms of our analysis to begin with?

A. Promises, Just Agreements, and Social Contracts

In 1991, Norman Daniels took up our question in the context of HIV infection and argued for a duty to treat, under conditions of personal risk, based on an analysis of ‘consent’ (Daniels, 1991, pp. 36–46). In his treatment, Daniels considers the AMA’s 1847 claim that a physician is expected to treat “without regard to the risk to his own health.” Daniels believes this is an extreme and unrealistic view. He writes, “We must believe that there are some limits, however vaguely specified, to the risks physicians have agreed to face” (Daniels, 1991, p. 38). Daniels then constructs a basic argument for the duty to treat in terms of what he calls a middle ground or a “modified AMA position.” Generally speaking, his argument runs as follows: Since physicians have consented to some (vaguely defined) standard of risk when they enter the profession, if the circumstances (HIV, bioterrorism, etc.) fall under that standard of risk, then there is a duty to treat even at personal risk if the risks fall within that standard.

However, a stronger case for the moral correctness of such a duty to treat would follow if a *promise* was made that was uncoerced, well realized, and unfoiled by extenuating circumstances. While a well realized promise implies consent, the converse implication doesn’t hold. I can consent to care for someone for a certain amount of money without promising to do so. To say “I promised” is too strong. But why? My suggestion is that when

we promise sincerely it is usually not only by way of our consent, but with a concurrent commitment to some relevant moral good. In effect, when we promise, there is a second order consent made regarding the moral *rightness* of the agreement, not only to its terms of *acceptability*.⁷

Consequently, emphasis on the notion of “promises” is given here to counterbalance the voluntarism sometimes associated with “consent” and “contract” language. John Arras, for instance, argues that “[b]y stressing the voluntary nature of the physician-patient ‘contract,’ bioethicists have inadvertently reinforced the notion that physicians, as free moral agents, have a perfect right to choose whomever they wish to serve” (Daniels, 1991, p. 11). In cases such as a bioterrorist attack, we are dealing with circumstances where patient vulnerability is heightened beyond any resemblance to a contractual agreement between free and equal parties. Arras writes, “[t]his claim to contractual freedom, enshrined in the 1957 AMA *Code of Ethics*, likewise fails to address the question of whether physicians have a special duty to enter into contracts with hazardous patients” (Daniels, 1991, p. 11). Why then a promise? The promissory quality of a duty to treat includes a commitment to values of beneficence and justice in addressing the special vulnerability of persons caught and compromised by such misfortunes. In sum, contractual language is primarily associated with legalistic negotiations concerned to maximize the self-interest of free and equal parties; a promissory duty to treat would be embedded in broader altruistic concerns.

While emphasizing the altruistic basis of a duty to treat, I do not mean to abandon the language of contacts altogether. Indeed, as we will see, it is ultimately a set of contractual elements that preserves the special arrangement between the medical profession and society. One might say that while altruism is the moral hub of the arrangement, the contractual structures are its spokes.

Prior to 1980, the AMA included clear language that appeared to constitute a public promise to treat and it is the longstanding emphasis on the priority of patient benefit that gives the contractual relation its promissory quality. While such language drops out in the 1980 and 2001 *Principles*, that lapse should not undermine the promissory quality of the duty to treat that was explicitly rendered from 1847 to 1955. Indeed, in the 2001 Declaration of Professional Responsibilities we have seen the language reemerge as part of the AMA’s “Social Contract with Humanity.” And while we have been told that the Declaration should not be taken as a ground for interpreting the *Principles*, general principles of clarity and consistency would place the burden of notice, for such a change, squarely on the AMA leadership.

It should go without saying that changes in a fundamental ethical and political document, like the AMA *Principles of Medical Ethics*, must be attentive to norms of clarity and consistency. Substantive changes need to be articulated, argued, and publicized widely as a condition of such changes. Consequently, a mistake was made when the phrase regarding expectations

of “temperate public opinion” was dropped without comment from the 1980 and 2001 *Code*. However, allowing the phrase to lapse without comment does not permissibly allow the meaning of the phrase to lapse from the 1980 and 2001 *Principles*. The longstanding history of this phrase (from 1847 until 1980), along with a failed obligation to articulate reasons for its departure, suffice to preserve its meaning holistically intact until such reasons are made public.

Furthermore, the promissory quality of the duty to treat has arrived in the public domain by proper channels and without taint of moral defect. The profession has made implicit and explicit promises as part of a general strategy of social negotiation aimed at establishing a just arrangement of shared benefits. The relationship developed between society and the medical profession thus constitutes an instance of a justly designed agreement that satisfies what is one of the clearest instances of an actual and vital social contract. Consequently, shouldering the obligation to treat, even under conditions of personal risk, is not an unrealized, uncompensated, or even an uninvited burden that has been foisted upon the profession. Indeed, by taking the initiative to respond to broader societal issues, especially in cases of a critical human need, physicians act to strengthen their own standing as stewards in this contractual public trust. Ultimately, such actions promote the autonomy and flourishing of the profession itself (Clark, 2001, pp. 11–29).

B. Do Institutional Promises Imply Individual Duties?

At this point, let us ask if the moral force of institutional promise making actually trickles down to the individual members of the profession. It seems evident that some members of the profession might feel that institutional promises have no binding force on their actions since they have made no such promise themselves. John Arras has taken this problem to be central in rejecting social-contractarian arguments for a duty to treat in favor of a virtue ethics that focuses on individuals and character formation. Speaking specifically about the problem of treating AIDS, Arras writes, “. . . virtue ethics would firmly rule out most voluntaristic arrangements for providing care . . . the virtue-based approach incorporates a willingness to treat hazardous patients into its notion of the good physician” (Arras, 1988, p. 15). Contrary to Arras, I will argue for a duty to treat along contractarian lines. Using Rawls’ “no free rider” principle, the goal will be to show that *as individuals* AMA physicians have a duty to treat during a public crisis. The approach is not incompatible with virtue ethics. Indeed, once a general argument can be established for having a duty to treat, I believe the virtue approach is the best way to instill the character traits required of the good physician.⁸

So the question now is whether those who have taken advantage of professional membership have a *prima facie* obligation to acquiesce in the

position of their representatives. John Rawls addresses this point by invoking a “no free rider” principle that holds for certain social arrangements.

This principle holds that a person is required to do his part as defined by the rule of an institution when two conditions are met: first, the institution is just (or fair), that is, it satisfies the two principles of justice; and second, one has voluntarily accepted the benefits of the arrangement or taken advantage of the opportunities it offers to further one’s interests. The main idea is that when a number of persons engage in a mutually advantageous cooperative venture according to rules, and thus restrict their liberty in ways necessary to yield advantages for all, those who have submitted to these restrictions have a right to a similar acquiescence on the part of those who have benefited from their submission. (Rawls, 1971, p. 96)

Rawls’ point indicates that if members of a profession, or other social arrangements, willingly profit from the rules and restraints of those arrangements, a *prima facie* right arises to expect all members to acquiesce in those rules and restrictions.

We should not be tempted to think that the “no free rider” principle could be challenged by a question of shifting priorities to address circumstance. Arras, for example mentions that a recalcitrant physician might agree that she has a duty to treat, but not when it conflicts with more important duties to self and family. “The central disagreement,” he writes, “is whether the *professio* of healing entails a commitment to the other above oneself” (Arras, 1988, p. 13). This problem might hold sway outside of the AMA *Code* and contract, but if the commitment is promissory, as it was argued, then the commitment is primarily other regarding. Further, as we have seen, priority juggling is forcefully ruled out in the AMA Principles. In fact, with a long history of stressing the primacy of patient benefit, the AMA, in 2001, underscored the priority as one of “paramount” importance. Since we have also shown that in public emergencies, the duty to treat trumps the autonomy rights of AMA physicians, it appears that the language of patient benefit applies *a fortiori* to the duty to treat in a public emergency.⁹

C. A Fundamentally Unjust Arrangement? The Libertarian Challenge

Let us consider one more challenge to the connection between institutional promises and individual members of those institutions. What, for example, do we say to those who deny Rawls’ condition on “fairness” and assert that such an arrangement is simply unjust and unfair to begin with. The libertarian spirit of Hospers (Hospers, 1971), Nozick (Nozick, 1974), Machan. (Machan, 1989), and others, would mount strenuous resistance to *any*

regulatory rules or restrictions that smack of obligating us to be “our brother’s keeper.” A guiding idea found in most varieties of libertarian thought is a Lockean view of rights, such that,

Individuals in Locke’s state of nature are in a state of ‘perfect freedom to order their actions and dispose of their possessions and persons as they think fit, within the bounds of the law of nature’ ... [namely] that ‘no one ought to harm another in his life, health, liberty, or possessions.’ (Nozick, 1974, p. 10)

Hence, for Lockean libertarians, restrictions in social arrangements are justified only on grounds of protecting individual freedom and property.¹⁰ We certainly may render aid to those in need, say the libertarians, but it is unjust in a fundamental way to bind anyone to do so without their uncoerced consent. However, perhaps we can view the question as one about whether citizens of a democratic society are ever bound to follow what appears to them to be unjust social arrangements.

Before doing so, we should note that in Rawls’ “no free rider” principle, it doesn’t follow that if his two conditions are *not* met (i.e., a “just institution” and “voluntary acceptance of advantages”), we are thereby entitled to conclude we are released from any further obligation. This would be an instance of the fallacy of denying the antecedent. Even if Rawls’ two conditions imply a “no free rider” principle, it doesn’t follow that should the conditions fail to be met, we are thus free to be “free riders.”

Consequently, let us shift the question to whether it is ever just to follow unjust arrangements. On this score, Rawls argues that there is a clear justification for following unjust social regulations if we accept one of the defining principle’s of democracy itself: majority rule. Democratic elections portray the point vividly. Commitment to the democratic process runs deeper than to the outcomes of the process.

But for Rawls, the principle of majority rule is neither final nor flatly coercive. Submission to majority rule applies only to the regulation of conduct, not to our judgement. Hence, majority rule for particular cases is revisable through open debate yet constraining on our conduct in the meantime.

The right to make law does not guarantee that the decision is rightly made; and while the citizen submits his conduct to the judgement of democratic authority, he does not submit his judgement to it. And if in his judgement the enactments of the majority exceed certain bounds of injustice, the citizen may consider civil disobedience. (Rawls, 1999, p. 181)

For Rawls, once we accept the principle of majority rule, the necessity of imperfect procedural justice will lead inevitably to rules and restrictions that may be viewed as unjust. But such a sense of injustice, in these terms,

does not yet give us reason to violate democratically established rules. For Rawls, while the democratic process binds us to submit our conduct to such arrangements, we are free to exercise our judgement and to voice our opposition in open debate. Failing such persuasions, dissenters are bound to submit their *conduct* to the majority will, even if their judgement and voice refuse to follow. And finally, when the dissenter believes the injustices are great enough to warrant outright civil disobedience, such measures must rest “on political conviction as opposed to a search for self or group interest...” (Rawls, 1999, p. 181) As such, acts of civil disobedience are to be conscientiously designed to bring about changes in law or policies in public, non-violent, conscientiously delivered terms, and with a willingness to accept legal and political sanctions if that is the price of non-compliance (Rawls, 1999, p. 182).

The answer to the libertarian challenge is thus restricted to those who willingly accept advantages of the profession (or social arrangement) and who accept the principle of majority rule in some appropriate form.¹¹ The point is that those who conscientiously disagree with the social arrangements, yet agree with the principle of majority rule, should find themselves bound to submit their conduct to the majority will as long as they are free to voice their dissenting judgements. Failing efforts at internal and public acts of persuasion, the dissenter may be forced to decide if the apparent injustices are great enough to justify actions of civil disobedience, or ultimately, in a Jeffersonian spirit, present their case before the public and declare their independence from the current leadership.¹²

IV. SEEKING A MINIMAL STANDARD FOR RENDERING AID

Let us now set the language and history of the AMA *Code* aside and ask whether persons generally have moral duties to render aid to others, and whether such obligations might continue to exist if rendering aid brings persons into circumstances of personal peril?

Alexander and Wynia point out that a variety of arguments have been offered supporting a duty to treat under conditions of personal risk, but they claimed, “[e]ach of these arguments has limitations and none can provide specific guidance as to the exact degree of risk to be undertaken (e.g. where does duty give way to heroism, and heroism to martyrdom?)” (Alexander & Wynia, 2003, p. 195). In what follows a general qualitative standard will be enunciated. It will be contended that while persons generally have obligations to assist in “minimally decent” ways, in the face of a critical human need, the standard of aid is sensitive to our ability to assist. Consequently, special abilities create greater obligations to assist beyond those of the average citizen. This is particularly true in the case of

physicians and those who lack such knowledge and training. Fortunately, the project of promoting medical awareness and training for dealing with bioterrorism is underway. For instance, in a new book titled, *Bioterrorism: Guidelines for Medical and Public Health Management*, (Henderson, 2002) we can find chapters on “Bioterrorism on the Home Front: A New Challenge for American Medicine,” “Bioterrorism Preparedness and Response: Clinicians and Public Health Agencies as Essential Partners,” and “Anthrax as a Biological Weapon: Updated Recommendations for Management.” But even with such information flourishing in medical circles, obligations to “oneself” and to considerations of effectiveness in service will properly limit physician’s obligations to assist.

A. General Argument for a “moral minimum”: Revisiting the Kitty Genovese Case

Following Judith Jarvis Thomson, a general argument for the duty to assist has been invoked from the parable of the Good Samaritan (Thomson, 1971, pp. 47–66). Thomson motivates the issue with the case of Kitty Genovese. On March 13, 1964, in Kew Gardens, Queens, 38 people watched and did nothing to help as Kitty Genovese was stabbed repeatedly. Hearing voices and shouts, her attacker fled but returned shortly to attack and finally kill Kitty Genovese. There was no response to render aid from the 38 witnesses, not even a phone call to police. Simon, Powers, and Gunneman have also used this horrible incident as paradigmatic for defining a general “moral minimum” for assisting others in the case of a “critical human need” (Simon, Powers, & Gunnemann, 1997, pp. 61–66). Speaking about the Kew Gardens case they note,

What so deeply disturbed the public’s moral sensibility was that in the face of a critical human need, people who were close to that need and had the power to do something failed to act. (Simon et al., 1997, pp. 63)

The point of having a duty to assist during such a critical human need has useful points of contact to the question of physicians and their obligations outside of the physician and patient relationship. In light of the case of Kitty Genovese, does it seem reasonable to conclude that we all have some moral duties to assist? If so, what would the range and extent of such duties amount to?

Thomson opens the question by drawing a three-fold distinction on the notion of samaritanism. According to Thomson, there are not only “good Samaritans,” but “splendid Samaritans” and “minimally decent” ones as well. Thomson points out that the witnesses to the murder of Kitty Genovese fell below what counts as even minimally decent and that is a standard none of us should fall below.

But how might we apply this notion of minimal decency to the present case of physicians and personal risk? Perhaps we can begin by noting that what counts as minimally decent behavior, in the face of a critical need, is sensitive to degrees of ability to render aid. If I am trained in water safety and life saving, my obligation to assist a drowning victim is greater than the average bather on the beach. Note too that by virtue of my training, my own personal risk is reduced relative to the average bather. Consequently, given the expert knowledge and training of physicians, in the relevant cases, the minimal standard of rendering aid is higher for physicians than it is for the average citizen, even though both have obligations if the need is critical. The point is that what counts as minimally decent behavior will vary with a person's capacity to render aid.

Simon et al. (1997) go so far as to argue that in emergency situations, certain omissions to render aid are tantamount to "sins of commission."

Life is fraught with emergency situations in which failure to respond is a special form of violation of the negative injunction against causing social injury: a sin of omission becomes a sin of commission. (Simon et al., 1997, p. 63)

Doing nothing is not always an omission. I might, for example, insult you by doing nothing when you reach to shake my hand at a company picnic. The point is that certain kinds of social expectations, if not met, become tantamount to violations of commission. We have seen how the AMA has long recognized duties embedded in social expectations when they speak of a duty to act "when temperate public opinion expects it."

This tacit awareness of negotiated social expectations has been the subject of important sociological literature. Paul Starr, for example, has argued that the medical profession would have been unable to sway society into deference to its authority unless the profession had been able "to satisfy the felt needs of others" (Starr, 1982, p. 144). Eliot Freidson, too, has commented that the process of social negotiation and persuasion by the medical profession has led society to believe that the profession is worthy of maintaining itself as a self-regulative autonomy. He also mentioned that "[t]he occupation's training institutions, *code of ethics*, and work are attributes which figure prominently in the process of persuasion...." (Freidson, 1971, p. 81; my italics).

So, Thomson's point about "minimal decency" is ratcheted up for members of the medical profession by *three* factors. First, since the ability to render aid is greater, the obligation to assist is also elevated. Second, by consideration of Daniels' argument that by freely joining a profession designed to combat disease, one consents to some standard of risk, and third, by realizing that the profession has flourished due to socially negotiated promises to be available in such times of duress.

B. Four Factors in Obligations to Assist: Need, Proximity, Capability, and Last Resort

Based on the case of Kitty Genovese, Simon et al. (1997) proceed to isolate four distinctions that would generally be present in cases where there is widespread agreement about a moral obligation to render aid.

The salient features of the Kitty Genovese case are

1. critical need;
2. the proximity of the thirty-eight spectators;
3. the capability of the spectators to act helpfully (at least to telephone the police); and
4. the absence of other (including official) help: i.e., the thirty-eight were the last resort.

There would, we believe, be widespread agreement that a moral obligation to aid another arises when these four features are present (Simon et al., 1997, p. 63).

C. Qualifications and Comments on the Four Factors¹³

1. NEED

The notion of need works to lever upwards the degree of responsibility to render aid. The greater the need the greater the level of responsibility to act. As to the case of physicians, it has been argued that physicians, as with all of us, have moral obligations to render aid. But since, in the relevant cases, physicians have greater obligations based on expert knowledge and ability, the obligation of physicians to render aid appears to be partially proportional to the extent of the need (AMA, 2002b, p. 145).

2. PROXIMITY

Proximity need not be spatial. Proximity is largely a function of notice. Blame accrues to one who knows of imperilment and does not do what can reasonably be done to remedy the situation. Simon et al. (1997) argue that,

Ignorance cannot always be helped, but we do expect certain persons and perhaps institutions to look harder for information about critical need. In this sense, proximity has to do with the network of social expectations that flow from notions of civic duty, duties to one's family, and so on ... Both factors—actual notice and constructive notice growing out of social expectation—enter into the determination of responsibility and blame (Simon et al., 1997, pp. 64–65).

Once again, the point about notice, ability, and blame appears to have been anticipated in literature of the *AMA Code*. We have seen longstanding recognition, in the *AMA Code*, of something like a “command to service” generated as it has been from the expectations of “temperate public opinion.”

2.1. Proximity and the Physician’s Professional Role. There is an argument that the self-regulatory interests of the medical profession are supported by an implicit social arrangement in contractual terms. This social contract parallels the point about “social expectations” mentioned above, but the argument goes further to assert that these expectations are based on a process that has been socially negotiated by the medical profession itself. As Paul Starr has written,

If the medical profession were merely a monopolistic guild, its position would be much less secure than it is. The basis of its high income and status ... is its authority, which arises from lay deference and institutionalized forms of dependence. The private interests of physicians alone would be insufficient to sway the society had they been unable to satisfy the felt needs of others. (Starr, 1982, p. 144)

According to this argument, then, the medical profession has provided notice, however implicit, of a commitment to address the “felt needs of others.” The return for such investment has been that the medical profession has been granted the status of professional autonomy and function as stewards of a contractually based public trust. Consequently, if there is a social expectation that the medical profession has an obligation to render aid, even at personal risk, such an expectation can not be taken lightly by the profession. As argued by Simon et al. (1997), omissions in cases of legitimate expectations are apt to be seen as “a violation of the negative injunction against social injury: a sin of omission becomes a sin of commission.” Clearly, the medical profession needs to monitor and address what social expectations are in these contexts.

In practical terms, if we grant the contractual nature of this profession’s public trust it would indicate that the medical profession would do well to query public expectations regarding physician involvement in settings of personal risk, such as those faced in a bio-terrorist attack. The public findings should lead either to assurances of a commitment to action from the profession or to educational initiatives that debate the legitimacy of such public expectations

3. CAPABILITY

Following Kant’s principle that “ought implies can,” we see that proximity requires the ability to do something that can help. Here, the expert knowledge and ability of the physician would again lead to a higher burden of responsibility to render aid.

4. LAST RESORT

Responsibility also increases as the likelihood that someone else can render aid diminishes. Simon et al. (1997) mention that with individuals, the larger and more complex a social structure, a growing sense that someone else will step forward ensues. Simon et al. (1997) mention this as a probable factor influencing the behavior of the thirty-eight witnesses in the Kitty Genovese case. But in medical contexts, because the third factor of capability is so heavily skewed in favor of those with direct medical knowledge and training such as physicians, nurses, EMTs, and so on, the idea that someone else can render the appropriate aid doesn't carry much force.

D. Duties to Self and Personal Risk Factors Restricting Obligations

Lastly, the treatment of these four factors needs to be considered specifically in the context of personal risk. Other things being similar, we can say that as individual risk increases, the responsibility to render aid diminishes. For instance, one might speak of the splendid Samaritan who throws himself between an attacker and an innocent victim to thwart the attack. But such splendid behavior is too high a standard to expect. What we are seeking are minimal guidelines that we can reasonably expect and that have the best chance of succeeding along the way.

It has been noted that due to expert knowledge and ability, physicians have obligations more like lifeguards than the average bather on the beach. Similarly, during national threats affecting the health and safety of its citizens, such as injuries and illness resulting from terrorism or bioterrorism, physicians carry a higher burden of responsibility than the average citizen does, though both have obligations. Even so, personal risk, when substantial, may exempt us from obligation to others. Our lifeguard would surely be excused from normal life-saving expectations if a drowning victim is seen caught in a strong current that plunges precipitously over a lofty cliff. Indeed, it is likely that splendid Samaritanism, in such cases, would not only fail to contribute to the critical need, but is likely in fact to compound it. The point was made long ago by Aristotle. Courage unmatched by wisdom often leads to rashness. That is, to behavior that undermines optimal effectiveness, improves nothing, and may even cause greater general harm than good (Aristotle, 2000).

V. CONCLUSION

The above considerations have led to the conclusion that the AMA *Code* along with physicians' special abilities create special obligations to assist in the face of a critical human need, even if personal risk is involved. We have

borrowed Thomson's notion of "minimal decency" as a qualitative standard that needs to be met. All physicians should have a clear sense firmly in mind that they should "do something" that is minimally decent in the eyes of their medical colleagues. Some, of course, will do more than that. However, physicians' obligations to themselves and to needs of optimal effectiveness should temper such obligations. Since risk is ubiquitous, the issue, of course, is one of degree. While decisions will vary according to the situation and individual judgement, it has been noted that special training inherent in the profession should provide a degree of protection not available to the average citizen. It would be wise policy for the profession to reintroduce greater emphasis on infectious diseases, especially targeting the threats and measures that can be taken against anthrax, smallpox, and other biohazards.

The standard of "minimal decency" should be understood clearly as what it says: *a minimum*. Setting such a minimal standard does not preclude more proactive responses. The value of such a standard lies in establishing a clear bottom floor. During times of fear and panic, getting started, in a way that is relatively easy to accomplish and without great danger, can have a cumulative and liberating effect on the practitioner. The importance of such first efforts is well expressed in the Chinese adage that "a journey of a thousand miles begins with one step," or in the children's allegory of "The Little Engine That Could."

Thomson noted with horror that in the Kitty Genovese case, no one even picked up a telephone. Surely if one has the capability to reach and operate a telephone, this would be a clear case of minimal decency. In a similar way, the medical professional could take the telephone analogy to initiate consideration of a professional minimum. For instance, advanced planning to maintain up-to-date lists of telephone numbers to reach the Center for Disease Control and Prevention (CDC) and the Emergency Response Office at the CDC (770/488-7100), the American Red Cross, US Public Health Service (800-872-6367), BIOPORT (517/327-1500) (producers of anthrax vaccine), the local Federal Bureau of Investigation (FBI) Field Office, and local public health directors are good for openers.¹⁴ Making phone calls, however, can be accomplished without professional medical skills.

The duty of medical professionals is greater. Wynia and Gostin have identified three dimensions of these greater duties in public emergencies: detection, containment, and treatment (Wynia & Gostin, 2004). After advanced planning, just mentioned, there is thus the need for the crucial diagnostic abilities of professionals to detect actual cases of biohazards and not be confused by false similarities with other conditions like influenza. Other minimal actions might include treating anxiety in persons not exposed to biohazards but who suffer from fears of having been exposed or actually experiencing somatic symptoms (i.e., reassurances or even diazepam-like anxiolytics for those not responding to reassurance).

Beyond that, physicians should be prepared to provide immediate volunteer service at local hospitals and clinics where services are compromised by large clusters of patients arriving for treatment. In return, special efforts should be in place to set aside vaccines and other therapies for professionals to insure that health professionals are able to perform and be protected in their work (Wynia & Gostin, 2004). The point of protecting the helper first, for optimal effectiveness, is well made by the airline's recommendation that if oxygen masks are dropped due to a sharp decline in cabin pressure, persons should secure their own masks before acting to assist others.

What has been mentioned above is only a bare suggestion intended to give some working substance to the standard of minimal decency in the context of physicians facing outbreaks of biohazard. Clearly, the topic needs much greater articulation.

The medical profession has deep social connections and investments, and over the years it has realized hefty benefits. As such, recognition of these facts warrants clear public disclosure and fuller awareness within the professional membership. It bears repeating that taking the initiative to respond to broader social issues of personal risk, especially when faced with a critical human need, is not only designed to help patients in need. It must be understood in the profession that by such proactive measures physicians actually promote the self-regulating interests of their own profession by strengthening the professions standing in a contractual public trust. In light of the contractual elements of the profession's role, it is urged that presently the medical profession needs to move quickly to query public expectations regarding physician involvement in settings of critical human need and personal risk to physicians. The findings could then be used to initiate public assurances or to stimulate educational initiatives querying the legitimacy of such expectations.

ACKNOWLEDGMENTS

I wish to thank Matthew Wynia, Timothy Murphy, Sara Taub, Karine Morin, Audiey Kao, Amy Hannon, Nancy Fama, and two anonymous reviewers for useful suggestions, comments and criticisms. Much of this article was written while serving as a visiting scholar at the Institute for Ethics of the American Medical Association and it was completed from the Donaghue Foundation as a visiting scholar at Yale University.

NOTES

1. Unlike the US system, delegates from the states are often appointed rather than elected. However, the process is democratic in that proposals are accepted or rejected by a majority vote from the House of Delegates.

2. www.ama-assn.org/ama/pub/category/4256.html. Accessed on December 11, 2002.

3. The problem of autonomy rights obscuring societal obligations, in the *AMA Code*, is developed in the essay cited in note 1 above. Part of the stimulus behind the essay came from years of teaching the *Code* to undergraduates who too often viewed Principle VI cynically as a physician's "escape hatch to Scarsdale."

4. Regarding the logical point, the step from 'any' to 'every' can sometimes cause confusion. Logic primers tell us that 'any' can be contextually ambiguous between the universal quantifier and the existential quantifier. Hence, the proper quantifier cannot be read trivially from the word alone. The quantifier must be interpreted from the context in which the word is used. The claim, thus, is that the context at hand is most naturally expressed in standard first order logic with a universal reading of the quantifier.

5. For another reference to the duty to treat as part of the tradition see text under "Medical Risk to Physician and Patient," *American College of Physicians Ethics Manual*, 4th Edition. Available at: www.acponline.org/ethics/ethicman.htm. Accessed December 10, 2002.

6. *Ibid.* p. viii. The original phrasing in 1984 reads: "...no Principle can stand alone or be individually applied to a situation. In all instances, it is the conglomerate intent and influence of the *Principles of Medical Ethics* which shall measure ethical behavior for the physician." AMA (1984). *Current Opinions of the Judicial Council of the American Medical Association*, Preface, p. vi.

7. Promising often occurs as a special reassurance in the context of doubt or of a difficult task to accomplish. For example, after missing an anniversary dinner date, due to an emergency meeting at work, I might promise never to let it happen again, emergency meetings notwithstanding. The key idea is that not only do I consent to being present at the anniversary date, but in promising I give special reassurances regarding the overriding rightness of being there.

8. Arras's ambitions to ground a duty to treat are with respect to the medical profession generally. My ambitions are focused more narrowly on AMA physicians. This is largely because the ethical literature from the AMA constitutes the most extensive, articulate, and dialogical body of ethical opinions in medical ethics available. The AMA also stands as the major umbrella organization of physicians in the United States.

9. This is not to say, of course, that physician's should abandon existing patients under such circumstances. What it does imply is that the condition of existing patients and the severity of public need be prioritized.

10. It is notable just how closely the phrasing of Principle VI echoes the libertarian creed.

11. AMA members make an explicit agreement "to subscribe and adhere to the *AMA Principles of Medical Ethics*." The statement can be found for each physician under "Doctor Finder" on the AMA website: <www.ama-assn.org> Accessed on December 11, 2002.

12. A conscientious internal appeal, prior to severance from the AMA, for example, might be to challenge the AMA process to be more fully democratic. State delegates, for example, could be required to be elected rather than appointed.

13. The points made in this and the previous section borrow heavily from Simon et al., (1997) *op cit*.

14. For more from the Center for Disease Control and Prevention (CDC), please consult the CDC website at, <www.bt.cdc.gov>. On this site one can find a downloadable document titled: "Bioterrorism Readiness Plan: A Template for Healthcare Facilities" at:<www.cdc.gov/ncidod/hip/Bio/13apr99APIC-CDCBioterrorism.PDF> Accessed on December 11, 2002.

REFERENCES

- Alexander, G.C., & Wynia, M.K. Ready and willing?: Physician preparedness and willingness to treat potential victims of bioterrorism. *Health Affairs*, 2003, Vol 22, Issue 5, pp. 189-197.
- American College of Physicians. (2002). *Medical risk to physician and patient. In: american college of Physicians ethics manual*, 4th Edition. [online]. Available at: www.acponline.org/ethics/ethicman.htm.
- American Medical Association. (1984). *Current opinions of the judicial council of the American Medical Association*. Chicago: AMA Press.

- American Medical Association. (1958). "Principles of medical ethics." *The Journal of the American Medical Association (Special Edition)*. Chicago: AMA Press.
- American Medical Association (1912). *Principles of medical ethics of the American Medical Association*. Chicago: AMA Press.
- American Medical Association. (2002). "History of the principles of medical ethics." www.ama-assn.org/ama/pub/category/4256.html. Accessed January 17, 2005.
- American Medical Association. (2002). *Code of medical ethics: Current opinions*. Chicago: AMA Press.
- Aristotle. (2002). *Nicomachean ethics*. 2nd edition, Irwin, T., trans. Indianapolis: Hackett.
- Arras, J. (1988). *The fragile web of responsibility: AIDS and the duty to treat*. *The Hastings Center Report*, 18, 510–520.
- Austin, John L. (1962). *How to do things with words*, London: Oxford University Press.
- Clark, Chalmers. (1996). Except in emergencies: AMA ethics and physician autonomy. *Cambridge Quarterly of Healthcare Ethics*, V, 440–443.
- Clark, Chalmers. (2001). Trust in medicine. *Journal of Medicine and Philosophy*, XXVII (1), 11–29.
- Daniels, N. (1991). Duty to treat or right to refuse? *Hastings Center Report*, 21(2) 36–46.
- Freidson, E. (1971). *Profession of medicine. A study of the sociology of applied knowledge*. New York: Dodd, Mead & Company.
- Henderson, D. Inglesby, T., and O'Toole, T. (Eds.) (2002). *Bioterrorism: guidelines for medical and public health management*. Chicago: AMA Press.
- Hospers, J. (1971). *Libertarianism*. Los Angeles: Nash.
- Huber, S. J. and M. K. Wynia. When pestilence prevails...Physicians' responsibilities in epidemics. *American Journal of Bioethics*, 2004 4 (1), pp. W5-W11
- Machan, T. (1989). *Individuals and their rights*. LaSalle, IL: Open Court.
- Nozick, Robert. (1974). *Anarchy, state and utopia*. New York: Basic Books.
- Rawls, John. (1971). *A theory of justice*. Cambridge: Harvard
- Rawls, John. (1999). The justification of civil disobedience. In: S. Freeman, (Ed.) *John Rawls: Collected Papers*. Cambridge: Harvard University Press.
- Rodwin, Marc A. (1993) *Medicine, money, and morals: physicians' conflicts of interest*. New York: Oxford University Press
- Searle, John R. (1969). *Speech acts—an essay in the philosophy of language*. Cambridge: Cambridge University Press
- Simon, J.G., Powers, C.W., and Gunnemann, J.P. (1997). The responsibilities of corporations and their owners. in T. Beauchamp, and N. Bowie, *Ethical theory and business*, 5th Ed., pp. 61–66. Englewood Cliffs, NJ: Prentice Hall.
- Starr, P. (1983). *The social transformation of American medicine*. New York: Basic Books
- Thomson, Judith. (1971). A defense of abortion. *Philosophy and Public Affairs*, I (1), 47–66.
- Wynia, M., and Gostin, O. *Ethical challenges in preparing for bioterrorism: The role of the health care system*, pp. 2–3. *American Journal of Public Health*, 94 (7), pp. 1096–1102.
- Zuger, A., and Miles, S. (1987). Physicians, AIDS, and occupational risk: Historic traditions and ethical obligations. *JAMA*, CCLVIII: (14) 1924–1928.

