

An Ethical Framework: Health Emergencies and the Physician

BACKGROUND

Following extensive research and consultation, the Council of the College of Physicians and Surgeons of Nova Scotia (the College) has developed the following ethical framework that identifies values the College believes should inform decision-making by the province's physicians during a significant health emergency, such as a pandemic. The framework was developed using the ethical values identified in *Stand on Guard For Thee: Ethical considerations in preparedness planning for pandemic influenza*, (Upshur, R. et al. 2005), a report of the University of Toronto Joint Centre for Bioethics Pandemic Influenza Working Group.

An ethical framework examines the values that should inform decision-making. Unlike a policy or guideline, it is not prescriptive or dogmatic, and represents values rather than recommending a course of action. The College believes that such an ethical framework should be established in advance of a health emergency.

INTRODUCTION

The outbreak of Severe Acute Respiratory Syndrome (SARS) in Toronto in 2003 and the more recent risk of an influenza pandemic have focused attention on the need for ethical guidelines to assist physician decision-making in the event of a health emergency. Health emergencies create personal and professional conflicts for physicians. For physicians, this can require a new balance between individual interest and the defense of the public interest. (Collège des médecins du Québec, 2008).

Health emergencies represent exceptional situations that impose a serious threat to public health. They necessitate collective efforts and appropriate, timely strategies. In these situations, many of the high-level planning and policy decisions will be made by federal and provincial governments. Decisions regarding the delivery of health care and guidelines for health professions will be made by organizations such as district health authorities,

regulatory authorities and professional associations. However, physicians will need to make many important decisions at an individual level.

Procedural Values

In developing this ethical framework, the College adopted the five procedural values identified in *Stand On Guard for Thee*. These values call on the College to be accountable, inclusive, open, transparent, reasonable and responsive.

Accountability

The College's mandate encompasses public protection and patient safety. The College is accountable to society for the profession generally, while individual physicians are accountable to their patients specifically and to the College and society generally.

Inclusiveness

In the process of planning for (and reacting to) a health emergency, the College's decision-making process will be *inclusive*, taking into account views of its members and the public. Decisions will incorporate views of all stakeholders and there will be opportunities for public as well as professional input.

Openness & Transparency

The decision-making process must be open and transparent. Decisions should be publicly defensible. A communications plan should be developed in advance to ensure that information is effectively conveyed to stakeholders (such as government, the public and the profession) and that stakeholders know where to access accurate information.

Reasonableness

Decision-making should be based on evidence, principles and values that are agreed upon by relevant stakeholders. Decision-makers should be credible and held accountable for their decisions. They should be able to provide a rationale for all decisions.

Responsiveness

There should be consistent updates to the framework as new information emerges, in addition to methods to attend to disagreements and grievances. Responsiveness should take place in both formal and informal ways.

Substantive Values

Stand on Guard for Thee identifies ten substantive values that the College recommends to its members to guide decision-making at all levels in the event of a health emergency.

Individual liberty: Canadians hold individual liberty as an important principle. Restrictions to individual liberty should be proportional to the risk of public harm, and be necessary and relevant to protecting the public good.

Protection of the public from harm: It is a foundational principle of public health to protect the public from serious harm.

Proportionality: Restrictions to individual liberty as a result of measures taken to protect the public from harm should use the least restrictive means to address the *actual* level of risk to the community and be applied without discrimination.

Privacy: A right to privacy in the disclosure of health care information is central to an individual's rights. In a public health crisis, however, the obligation to protect the public from serious harm may override an individual's right to privacy. Private information should only be released if there is no less intrusive means to protect the health of the public.

Obligation to provide care: This principle is inherent in the CMA *Code of Ethics*, which states as a principal fundamental responsibility that physicians should "Consider first the well-being of the patient." (Canadian Medical Association, 2004, 1). Physicians will be met with significant challenges regarding resource allocation, scope of practice, professional liability, workplace conditions, and most importantly, addressing their personal risk versus their obligation to provide care for patients.

Reciprocity: This principle requires that if physicians are asked to take increased risks or face greater burdens during a health emergency, they should be supported by society in doing so. Risks and burdens should be minimized as far as possible. Social solidarity should flow in both directions. If, in the case of a health emergency, physicians have certain obligations towards society, then society has certain reciprocal obligations towards physicians.

The College believes that professional organizations such as the Canadian Medical Association and Doctors Nova Scotia play an important role in supporting this concept.

Equity: As stated by the *Canada Health Act*, "the primary objective of Canadian health care policy is to facilitate reasonable access to health services without financial or other barriers." (Canada. Department of Justice, 1985 c. 6, s. 3.). Due to resource limitations, the onset of a

pandemic will pose difficult decisions regarding which health services can be reasonably provided. Patients with greater health care needs will require more resources. For example, in the midst of pandemic, decision-makers, including clinicians, must attempt to maintain the principle of equity when considering the interests of influenza patients as well as those requiring treatment for other diseases.

Trust: Decision-makers should attempt to build trust with stakeholders prior to the onset of a crisis, and ensure that decision-making processes are ethical and transparent to those affected stakeholders. Trust is a fundamental issue in the relationship between the medical profession and society.

Solidarity: The process by which decisions makers at all levels set policies and guidelines for dealing with a health emergency must be collaborative, in a spirit of common purpose, and for the mutual good; within and between health organizations. Solidarity also requires that decision makers and clinicians support positions arrived at by consensus and uphold them.

Stewardship: Both institutions and individuals will be entrusted with governance over scarce resources (such as vaccines, antivirals, ventilators, hospital beds, and health professionals). Those entrusted with governance should be guided by trust, ethical behavior and good decision-making based on evidence and reason. (Upshur, R. et al. 2005, p8).

In its examination of the role of physicians in health emergencies, the College focused on three distinct areas: obligation to provide care, restrictive measures and priority setting.

OBLIGATION TO PROVIDE CARE

There is an ethical obligation to care for patients, even in the face of risk, that extends to all physicians.

According to the World Medical Association, “Physicians have an ethical responsibility to provide services to the injured or ill. They should have resources in place in the event they and/or their own families become infected.” (2006, s.11h). This ethical obligation incorporates but extends beyond physicians’ well-established legal duty of care to patients with whom they have an established doctor-patient relationship. It originates from the acknowledged social contract between physicians and society, and the ethical obligations that flow from this contract. The special commitment of doctors to a high standard of altruism and beneficence, and consequently to an obligation to provide care even in the face of personal risk is a large part of the social contract between the profession and society. (Reid, 2005). Physicians hold a leadership role in society and the public will be looking to the profession to provide leadership during a pandemic.

Reciprocity implies that just as physicians have certain obligations towards society, society in turn has certain obligations towards physicians.

Reciprocity plays a key role in the social contract between physicians and the public. It must be acknowledged and understood that appropriate measures and resources will be in place during times of crisis if physicians are to face risks to help those in need. These include: Robust infection control measures, appropriate support for the families of physicians, suitable remuneration schemes and provisions for disability and survivor insurance for physicians. The College believes that professional organizations such as the Canadian Medical Association and Doctors Nova Scotia must play a central role in ensuring that these measures are in place.

The College does not support the conscription of physicians during a crisis such as a pandemic. Conscription in this sense is defined as a policy, usually enforced by law, that requires physicians to involuntarily provide their professional services. The College believes that *prior* arrangements to address physician labour supply during a crisis must be reached by key stakeholders including physicians, their professional organizations, health care institutions and governments. Within the physician community, fear of infectious disease may not be recognized as a legitimate reason for refusal to participate in patient care.

The Council believes that, as physicians, members of the College have a professional ethical obligation to help others in times of crisis. As stated previously, according to the Canadian Medical Association's *Code of Ethics*, a primary fundamental responsibility of physicians is to "consider first the well-being of the patient". Physicians must also "consider the well-being of society in matters affecting health" and "provide whatever appropriate assistance [they] can to any person with an urgent need for medical care" Certainly during a health emergency, there will be many urgent situations.

"The ability of physicians and health care professionals to provide care is greater than that of the public, thus increasing the obligation to provide care. By freely choosing a profession devoted to care of the ill, physicians have assumed risk." (Upshur et al., 2006, p. 3). During a health emergency, physicians should strive to provide as much assistance as possible to as many patients in need as they can. In spite of the fact that most physicians are self-employed, such professional autonomy should not stand in the way of physician participation. A physician's decision not to be involved during a health emergency shifts the burden to others (including fellow physicians) and places the public at risk.

Although the College sets the expectation that all physicians bear the same ethical obligation to care and will participate in some capacity during a health emergency, it is recognized that some physicians will have greater needs than others. The likelihood that many physicians will be responsible for the care of their own families will result in greater limitations of the provision of patient care during a health emergency. Limitations may vary depending on the

extent of personal risks to physicians and their families, some of whom will need more support than others.

It is the duty of society to see that the needs of physicians and their families are met if all physicians are expected to meet societal expectations to provide care in times of a health emergency. This is the essence of reciprocity.

Sample Scenarios:

Balancing obligation to provide care and responsibility to self and family

The following scenarios illustrate hypothetical situations that focus on the conflict between the physician's obligation to provide care and his/her responsibility to self and family that may arise during a health emergency. These scenarios are not intended to provide answers to these dilemmas or to indicate the Colleges' expectations of its members. Rather, they are provided to facilitate thought and discussion about these complex issues and to enable physicians to incorporate ethical principles into their decision-making in the event of these or similar situations.

Scenario 1

A 35 year-old anesthesiologist decides that she is not going to enter the hospital after learning about the onset of the first wave of a pandemic. She has two young children, and is currently breastfeeding her newborn infant. She and her husband, a firefighter, are also the primary caregivers for her elderly parents who reside in their home.

This scenario illustrates the complexity of a conflict between professional and family duties. A conflict exists between obligation to provide care, protection of the public from harm and individual liberty. This scenario demonstrates the need for support for physicians with greater needs, and the importance of reciprocity. It also demonstrates that physicians working in critical care settings may be placed at greater risk than others.

Scenario 2

A middle-aged internist is a diabetic and suffers from asthma. He decides he is not willing to risk caring for patients during the onset of the pandemic as he fears for his own health, and the possibility of contracting influenza.

This scenario illustrates a conflict between professional responsibilities and individual health and well-being. A conflict exists between the obligation to provide care, the protection of the public from harm, and individual liberty.

RESTRICTIVE MEASURES

The Nova Scotia *Health Protection Act* upholds the “authority to apprehend and isolate or quarantine” through the Medical Officer of Health (2004, s.39). In past situations, most physicians have complied with quarantine recommendations voluntarily. The Council believes that disobeying an order of quarantine should be considered physician misconduct unless extenuating circumstances exist. Physicians must exercise their best judgment and in the case of a complaint, their actions will be judged on a case-by-case basis. A well-defined process to appeal decisions of the Medical Officer of Health should exist to assist those who feel justified in their violation of quarantine.

Restrictions to individual liberty should be proportional to the risk of public harm, be necessary and relevant to protecting the public good, employ the least restrictive means necessary to achieve public health goals, and be applied without discrimination. (Upshur, R. et al. 2005). Society must provide quarantined physicians with access to suitable remuneration schemes and appropriate support.

PRIORITY-SETTING

Balancing the needs of individuals versus the greater good may be difficult during a crisis. For example, in a combat situation, military physicians may find themselves forced to provide scarce treatment resources only to those patients who are most likely to survive.

In the event of a health emergency, decisions will need to be made by health care providers and institutions rapidly and under difficult conditions. Physicians will likely be playing a role in these decisions. Protocols for clinical decision-making with regard to resource allocation and prioritization in times of a health emergency must be prepared well in advance and include public input. Decisions should be rational, practical, based on evidence, and be the result of an appropriate and transparent process. Arbitrary, hasty, discriminatory decisions must be avoided. A fair and rapid appeal process must be developed in advance.

Decisions regarding resource allocation, such as vaccine and anti-viral rationing, should be left to public health officials and may depend on the nature of the infectious pathogen. The College advises its members to comply with directives from Public Health authorities with regard to allocation of vaccines and anti-virals. Preliminary protocols indicate that health care workers and their immediate families will be prioritized for vaccination.

Effective coordination of communication is critical at all levels. Well-defined roles and expectations must be established. Help desks, web sites and other communication tools will be vital in order to relay necessary information to healthcare providers and the public.

Emergency plans should be tested within the community for feedback, to ensure that all stakeholders are aware of their respective roles. Efforts should be made to solicit public input in order to increase public awareness.

The College recognizes that it would not be acting in isolation in the event of a health emergency such as a pandemic. Government agencies, Doctors Nova Scotia, and other professional regulatory bodies hold distinct responsibilities that must be clearly delineated and coordinated in advance of any such emergency.

Sample Scenarios:

Setting priorities during a health emergency

The following scenarios illustrate two hypothetical situations involving priority-setting that may arise during a health emergency. These scenarios are not intended to provide answers to these dilemmas or to indicate the Colleges' expectations of its members. Rather, they are provided to facilitate thought and discussion about these complex issues, and to enable physicians to incorporate ethical principles into their decision-making in the event of these or similar situations.

Scenario 1

The first wave of the influenza pandemic has arrived and you are on call for the ICU. Every available ventilator is in use. The unit contains a number of patients in respiratory failure with overwhelming pneumonia (presumed due to influenza) along with the usual mix of patients with severe heart or lung disease, also requiring ventilation. An elderly patient is brought to your hospital in respiratory distress with all the clinical indicators of impending respiratory failure and is intubated in the ER. An emergency room physician calls you and requests you see the patient with a view to ICU admission.

This scenario illustrates the difficulty of implementing decisions requiring resource allocation at the clinical level. It also raises the importance of pre-planned decision-making protocols developed by a healthcare institution and formulated with public input. In addition, it exemplifies the necessity of having a rapid appeal process in place.

Scenario 2

You are a family physician with a community practice. The pandemic has arrived. Your waiting room is full and you are behind by one hour. The husband of one of your patients with asthma calls to say his wife has developed a severe cough and has a fever. He doesn't want to take her to the local emergency department or a triage center because of reported long waits (and an unspoken fear of exposure to influenza).

This scenario illustrates the importance of following community-developed protocols for infection control. Practitioners have an obligation to follow office-based infection control

measures. This scenario also illustrates the importance of public awareness of, and compliance with, primary assessment centres during a pandemic.

CONCLUSION

This ethical framework has been designed to assist physicians in their decision-making process in the event of a health emergency. Health emergencies are exceptional situations that do not relieve physicians of their professional responsibilities. In fact, a health emergency will likely challenge physicians to assume their roles with additional rigor. Ultimately, physicians are free to make the necessary independent decisions during the course of a crisis such as a pandemic, but they should be prepared to reasonably justify these decisions if necessary.

The College believes that physicians have an obligation to serve the public but shares the belief that social solidarity does not flow in one direction only. Reciprocity is essential; physicians have certain obligations to society during a health emergency, while society has reciprocal obligations toward physicians.

The College has put forward this ethical framework to assist its members in thoughtful consideration of the ethical conflicts they can expect to face in the event of a health emergency such as an influenza pandemic, and to reveal the substantive values that are felt to be of importance in such a consideration. The College expects that its members will take these into account when faced with difficult decisions involving conflicting values.

GLOSSARY

Altruism	The quality of selfless concern for the welfare of others
Beneficence	The quality of being kind, helpful or generous.
Duty of Care	A legal term that describes the duty of a doctor to exercise care with respect to a particular patient upon the formation of a doctor-patient relationship. This care includes attendance, diagnosis, referral, treatment and instruction.
Obligation to Provide Care	The expectation within the social contract that physicians and other medical professionals have particular obligations to provide care for patients who require it despite certain risks that this may entail to care providers.
Ethical Framework	A tool for structuring decision-making about ethical questions.
Pandemic	An outbreak of an infectious disease that involves large numbers of people and is geographically widespread.
Pathogen	An agent such as a virus or bacterium that causes disease.
Principle of Equity	Often likened to the Golden Rule (“Do unto others as you would have them do unto you”), the Principle of Equity was stated by Samuel Clarke (1675–1729) as follows: “Whatever I judge reasonable or unreasonable for another to do for me, that by the same judgment I declare reasonable or unreasonable that I in the like case should do for him.”
Procedural Values	Values that are related to the manner in which decisions are made.
Professional Autonomy	The power to make decisions regarding the management of a patient or client based on one’s own professional knowledge and expertise.

Professional Liability	Legal obligation created when an individual, such as a physician, offers specialized services to the general public.
Protocol	A rule or guideline that directs how an activity should be performed.
Quarantine	Voluntary or enforced isolation of patients suffering from a contagious disease or their contacts in order to prevent the spread of the disease.
Reciprocity	Reciprocity: The mutual exchange of support to serve a common good. According to Upshur <i>et al</i> (2005), “Reciprocity requires that society support those who face a disproportionate burden in protecting the public good, and take steps to minimize burdens as much as possible. Measures to protect the public good are likely to impose a disproportionate burden on health care workers, patients, and their families. If workers are to take high risks, there is a duty upon society, in particular on their institutions, to support them.”
Scope of Practice	Terminology used by medical regulatory authorities that defines the procedures, actions, and processes that are permitted for a particular licensed individual, such as a physician.
Social Solidarity	The degree of integration and connectedness shown by a society or group.
Substantive Values	Values that describe particular types of public good, such as liberty or equity.
Transparency	The qualities of open communication and public accountability exhibited by of an institution.

REFERENCE LIST

- Canada. Department of Justice. (1985). *Canada Health Act (R.S., 1985, c. C-6)*. Retrieved November 10, 2008 from: <http://laws.justice.gc.ca/en/ShowFullDoc/cs/C-6///en>.
- Canadian Medical Association. (2004). *CMA Code of Ethics (Update 2004)*. Retrieved November 10, 2008 from: <http://policybase.cma.ca/PolicyPDF/PD04-06.pdf>.
- Collège des médecins du Québec. (2008). *Le Medecin et les Urgences Sanitaires*. Retrieved November 10, 2008 from:
www.cmq.org/DocumentLibrary/UploadedContents/CmsDocuments/Position-urgences-sanitaires-2008.pdf.
- Nova Scotia. (1989). *Human Rights Act. R.S., c. 214, s. 1*. Retrieved November 10, 2008 from: <http://www.gov.ns.ca/legislature/legc/statutes/humanrt.htm>.
- Nova Scotia. (2004). *Health Protection Act. 2004, c. 4, s. 1*. Retrieved November 10, 2008 from: <http://www.gov.ns.ca/legislature/legc/statutes/healthpr.htm>.
- Reid, L. (2005, August). Diminishing Returns? Risk and Duty to care in the SARS Epidemic. *Bioethics*, Vol.19, no 4, 2005: 348-361.
- Upshur, R. et al. (2006). On pandemics and the duty to care: Whose duty? Who cares?, *BMC Medical Ethics*, v.7, 1472-6939-7-5. doi:10.1186/1472-6939-7-5.
- Upshur, R. et al. (2005, November). *Stand on guard for thee: Ethical considerations in preparedness planning for pandemic influenza*. Retrieved November 10, 2008 from: http://www.jointcentreforbioethics.ca/people/documents/upshur_stand_guard.pdf
- World Medical Association. (2006, October). *Statement on Avian and Pandemic Influenza*. Retrieved November 10, 2008 from: <http://www.wma.net/e/policy/a28.htm>.

DOCUMENT HISTORY

Approved by the Council of the College of Physicians and Surgeons of Nova Scotia,
March 27, 2009