How strong is the duty to treat in a pandemic?

Ethics in Practice Point: Counterpoint

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Case Presentation:

A healthy 31-year-old pediatric otolaryngology Fellow at an academic medical center receives an email from the medical center's leadership asking for the Fellow to give their willingness and availability to cover adult ICU shifts during the COVID-19 pandemic. The email describes an expected high clinical volume of COVID-19 patients that will outstrip current ICU physician staffing and includes a link to a training course for non- ICU trained physicians to care for critically ill COVID-19 positive patients. An additional email from the hospital asks the Fellow to serve on an intubation team along with anesthesiologists and adult otolaryngologists as part of their overall ICU service.

No elective cases are currently being performed due the COVID-19 epidemic. Emergency and urgent cases are still occurring, with the Fellow responsible for inpatient care. The pediatric otolaryngology division chief has stated that all emergency cases are to be done by faculty alone. The Fellow is married, has two children and is the only income for their family. There are no other Fellows in the program, and all otolaryngology residents on the pediatric otolaryngology service have been asked to leave the service to be deployed at the adult hospital. This case is hypothetical.

Point:

There is a strong duty to treat in a pandemic. Times of crisis mandate an "all hands on deck response". Due to this, the fellow should agree to participate to the best of their ability.

Otolaryngologists may understandably have significant reservations about providing care to patients in the midst of a pandemic, especially when this care is outside the normal scope of their practice. Despite the risks to oneself and unease with providing unfamiliar care, "Caring for the sick is what distinguishes health professionals from lawyers, teachers and businesspeople"[1]. Based on the principles of beneficence and justice, there is a strong duty to treat in the midst of a pandemic for three primary reasons. First, as a part of his or her profession, a physician inherently takes on risk when caring for patients. Second, physicians enter into a social contract that legitimizes and compensates them for their care, and this leads to an obligation to be available in an emergency. Third, all physicians are able to provide care for sick patients better than the general public, which increases their responsibilities in a public health emergency[2].

One of fundamental principles of the medical profession is the responsibility to care for the sick even at personal cost. The American Medical Association (AMA) code of ethics states that in an emergency, the "Obligation holds even in the face of greater than usual risks to physicians' own safety, health or life"[3]. Physicians implicitly accept certain occupational risks, including the risk of contracting an infectious disease, when they enter into the field of medicine. While the COVID-19 epidemic is in some sense unique, the underlying moral responsibilities of physicians to care for patients to the best of their ability do not appreciably change in a pandemic. In this particular case, the risk of severe COVID-19 infection to the Fellow physician may be lower than the general population given his or her age and good health. This may argue

towards the Fellow's preferential service compared to older physicians. Such volunteering by younger physicians is admittedly above and beyond the narrow obligation to care for the sick, but supererogatory action is something that surgeons aspire to every day in their practice[4]. While the risk the Fellow would be incurring as a part of the intubation team is not insignificant, with adequate personal protective equipment it is a reasonable risk for the Fellow to use his or her expertise with intubation in order to care for COVID-19 positive patients.

Physicians accrue significant societal benefits from their profession, including high compensation, job security, and societal prestige[3]. These benefits bind the physician to a social contract wherein they render necessary services in an emergency. For example, if a physician witnesses a car accident and sees a victim that is bleeding profusely from a limb, it is reasonable to expect that they use their expertise to place a tourniquet. Similarly, society can reasonably expect physicians to care for patients in the midst of a pandemic. This is partially by virtue of the significant resources that society has invested in the training of the physician, as it would be unjust to accept the benefits of being a physician while avoiding the risks and avoiding service in the time of greatest need. Even though the Fellow's strict job description does not state that as a pediatric otolaryngologist that they are required to care for adult patients, the training they have received has been heavily subsidized by society. While in "normal" times this would not be the case, the amount of public praise for health care professionals in the midst of a pandemic strongly argues that our society expects (and is thankful for) all providers to do their part in a pandemic[5].

A Utilitarian ethic also argues for a strong duty to treat. Otolaryngologists, even though they are not specialists in critical care, have a baseline knowledge and ability in caring for critically ill patients that is higher than the general population. With a shortage of healthcare

workers that would normally provide critical care, it is reasonable to ask the otolaryngologist to perform a duty that they are competent in (intubation) to mitigate the care burden for critical care and emergency physicians. If all physicians are involved to the best of their ability, this spreads risk more equitably throughout the entire population of health care providers. This argument is predicated, of course, on the availability of adequate PPE to avoid undue risk to health care providers. Assuming these basic assurances, the greatest good for the greatest number involves all health care providers involving themselves in pandemic care.

Past pandemics provide a roadmap for this one when it comes to the duty to treat. In the 2003 SARS pandemic, health care providers were widely praised as having gone above and beyond in their service to the sick[2]. This past legacy argues for a similar response to the COVID-19 pandemic from physicians. We must also look to future pandemics and how our response to the COVID-19 pandemic could influence the future. After the SARS epidemic in Singapore, bioethicists there praised the response of physicians, but then wondered: "How will medical professionalism be viewed if healthcare professionals could disclaim the duty of care in the face of a deadly pandemic?"[5]. For these reasons, endorsement of a strong duty to treat is necessary, and the Fellow should agree to care for COVID patients during the pandemic.

Counterpoint:

The need for physician capacity during a pandemic must be carefully weighed against healthcare worker safety, educational opportunity and personal obligations. The Fellow should ask for additional information and incentives prior to agreeing to serve in this capacity.

Caring for patients to the best of a physician's ability is the fundamental goal of the medical profession. However, in the midst of a pandemic there are competing ethical principles when considering the strength of the duty physicians have to treat. In this vignette, a pediatric otolaryngology Fellow is being asked to treat adult patients as an intensivist, and to do so in a manner that puts them at significant risk. For reasons of autonomy and non-maleficence, it is reasonable for this Fellow to ask some pointed questions about risk mitigation and the nature of their status as a trainee within the health system prior to agreeing to serve in the ICU.

As a provider that chose to specialize in pediatric otolaryngology, the Fellow has likely not cared for adult patients for at least a year. More importantly, to care for adults as an ICU physician is outside their scope of their practice and would not be accepted in non-pandemic situations as the standard of care, though recent ACGME guidelines indicate that, provided adequate supervision is provided, this is acceptable during the COVID-19 pandemic. Nonetheless, previous data suggests that physicians practicing outside of their specialty provide lower quality and higher cost care, thus a pediatric otolaryngologist caring for an adult patient in an ICU capacity may violate the principle of non-maleficence[6]. Given this, pediatric non-ICU providers should only care for adult patients after all adult physician capacity is exhausted. It is a false dichotomy to presume that caring for an adult patient with COVID-19 is ethically more

important than the future pediatric patient with an urgent or emergent otolaryngologic problem. The patient with COVID-19 can conceivably be cared for by any physician capable of endotracheal intubation, including anesthesiologists, critical care physicians, and emergency physicians. By contrast, a pediatric patient with an airway issue, such as an airway foreign body or severe bacterial tracheitis, should be taken care of by surgeon with specialized training in pediatric airway management. The most likely risk to the Fellow is not severe COVID-19 illness leading to disability or death (though this remains an important possibility), but rather that they will contract the illness and be forced into self-quarantine for a two week period, with an inability to provide care to pediatric patients that may require it during this time, and decreased educational opportunities.

In the unlikely event that the Fellow does contract a severe case of COVID-19 and is unable to practice, there are significant ramifications for the Fellow, but also for two other groups. First, future patients may not be able to obtain care. Pediatric Otolaryngology is a small specialty, and there are many areas of the country with limited access to a pediatric otolaryngologist[7]. Due to this, losing the services of even one pediatric otolaryngologist is significant. Second, according to the vignette, the Fellow is the sole provider for their family. The obligations of an individual to their family are highly ethically relevant, and may supersede even the responsibility the physician has to their patients under some ethical theories[8]. Due to this, any request the medical center makes of residents or Fellows to participate in pandemic care should be accompanied by appropriate compensation for risk, such as life/disability insurance and hazard pay. In addition, an assurance of adequate personal protective equipment availability is necessary for any duty to treat obligation to be expected.

Fellow/resident involvement in pandemic care adds significant ethical complexity. First, the primary responsibility of a Fellow is to become a competent provider in their specialty to allow them to care for future patients in their specialty[9]. To ask the Fellow to serve outside of their specialty is asking them to neglect their primary responsibility, and has downstream ramifications by decreasing educational opportunities in their field and potentially decreasing their competence level when they care for future patients. Second, and perhaps more importantly, the way Fellows are compensated is primarily through the education they receive, as their future (higher) earnings are almost entirely dependent on their specialized training. If a Fellow is asked to perform pandemic care without addressing these two factors, the medical center has failed to discharge their contractual obligation to train a competent physician, and has not appropriately compensated the Fellow (such as providing life/disability insurance) for taking on additional risk[10].

Finally, there is an element of coercion that goes along with being a trainee, with an accompanying blunting of the Fellow's autonomy. It is difficult to reject a request from a superior as a trainee. Being asked to participate in highly risky care is a perfect example of this situation. The analogy of a firefighter is apt to summarize the major points[3,10]. A firefighter is asked by their chief to enter a building and fight the fire at considerable risk to themselves, and this is reasonable. However, the firefighter is not compelled to enter a burning building if they are not given the appropriate equipment to decrease risk as much as is reasonable given the situation. Similarly, if a pediatric otolaryngology Fellow is asked to enter the burning building of COVID-19, it is reasonable for them to expect to be given appropriate protection (PPE, disability/life insurance, hazard pay) before they enter. For this reason, in absence of clear assurances by the medical center of these protections, the duty to treat is weak in this situation.

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