

Reviewer's report

Title: On pandemics and the duty to care: whose duty? who cares?

Version: 1 **Date:** 27 January 2006

Reviewer: Matthew K. Wynia

Reviewer's report:

General

This paper addresses an important set of issues that deserves more attention, as the authors correctly note. It also provides a useful summary of why codes of ethics are important to the health professions, and a brief history of the ethics of the duty to treat, though with some key recent points missing (see below). In addition, and more importantly, in the end the paper proposes only a few suggested means to foster a better social dialogue and that the medical profession take unspecified action (granted, three general options for action are given, but only very briefly and non-committally). A call for "open and honest discussion" might indeed be needed, but it would have been much more satisfying (and interesting) if the authors would try to lay out an ethical framework for understanding the health professional's duty to treat in a more robust, actionable way. Specifically, what are the "specific additions to current codes of ethics" that are urgently required?

Major Compulsory Revisions (that the author must respond to before a decision on publication can be reached)

P10 – While I agree with the authors that we should see more attention given to these issues in Codes of ethics generally, I must note that since 9/11 the AMA has adopted several new ethics policies, some of which were written specifically to address these issues. For instance, this is an excerpt from E-9.067 "Physician Obligation in Disaster Preparedness and Response" (adopted June 2004):

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

This comes from a longer report that provides additional thinking on this. In addition, in December 2001, in immediate response to 9/11 and the anthrax attacks that followed, the AMA recognized that a universal call to professionalism was needed, which should include a statement regarding the duty to treat (in part because 10 ambulances were crushed in the collapse of the World Trade Centers, and the threat of additional bioterror attacks was thought to be very high). As a result, the AMA adopted the Declaration of Professional Responsibility, which notes that physicians solemnly commit themselves to "apply our knowledge and skills when needed, though doing so may put us at risk." Almost all the state medical societies, many specialty societies and some international societies have now signed on to this Declaration (I'm not sure about Canada). The point is, given these newer statements, this paper really should comment more specifically on the weaknesses or strengths of the arguments the AMA has laid out.

Minor Essential Revisions (such as missing labels on figures, or the wrong use of a term, which the author can be trusted to correct)

P5, first paragraph: this paragraph ends with a promise to offer some potential avenues forward.

Unless the authors are willing to provide some more detail on avenues forward, this might be better re-phrased to simply promise to open the social dialogue and prompt further discussion.

P7, reference to Clark 2005 is missing in the reference list.

P11 – second paragraph: in fact, the statement on the duty to treat was not removed from the AMA code until 1977. In the 1950s the code was reformatted into 10 principles and a large set of interpretive notes (the same format it takes today), but the content was not otherwise changed and the statement on the duty to treat remained. Also, I would not call the notion that the ‘era of infectious diseases’ was coming to an end and the notion that the medical profession was focusing increasingly on professional autonomy, in fear of government and corporate intrusions, “competing” explanations for why the statement on duty to treat was ultimately removed. They are complimentary explanations and almost certainly both played a role. By the way, the only written evidence we have says that this statement and other pieces of the code dropped in 1977 were eliminated simply because they were “historically anachronistic.”

Also, at some point the paper should probably make some notice of the HIV epidemic and the fact that many statements about duty to treat were revised and reinstated at the time HIV became widely recognized.

Discretionary Revisions (which the author can choose to ignore)

P13, second paragraph: are there really only three options? The third option seems very broad. Would an option of a very strong duty, but not a limitless one, be acceptable as a distinct option? For instance, firefighters are expected to take some risks, but they are actually trained not to run into unstable structures, even in order to save lives (this is partly prudential for society, because a dead fireman, like a dead doctor, can't do much for the social welfare).

P13, bottom paragraph: What recent calls for danger pay or additional disability protections did the authors have in mind?

What next?: Unable to decide on acceptance or rejection until the authors have responded to the major compulsory revisions

Level of interest: An article whose findings are important to those with closely related research interests

Quality of written English: Acceptable

Statistical review: No

Declaration of competing interests:

The reviewer is an employee of the American Medical Association.