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The duty to treat and the realities of the 21st century

Severe acute respiratory syndrome (SARS), sarin gas, anthrax, hurricane Katrina, the September 11th World Trade Center attack–all of these, whether a natural disaster, a bioterrorist attack, or an epidemic infectious disease, cause injury and suffering. The injury and suffering affect not only the general population but also a specific group of people: those who have chosen to be health care providers. Even more specifically, those who have chosen or felt a "calling" to practice medicine as a physician or as a physician assistant belong to groups that may experience a disproportionate level of stress during times of health and safety disasters.

Every day, physicians and physician assistants interview, touch, and treat patients who are suffering from injury and disease. Occasionally, these patients pass colds, influenza, hepatitis, or other infectious diseases on to the clinicians caring for them. As physician assistants, we make ourselves vulnerable in this way because we have special knowledge to treat, and this provides us with a license to ask questions of, touch, and peer inside our fellow citizens. In doing so, we enter into a contract with society that carries expectations and obligations for both practitioners and society.[1]

As physician assistants, we have chosen to cast our lot with the House of Medicine, with all of the privileges and obligations that go along with it. The following case illustrates the sometimes harsh consequences of our decision. At the end of the case, we will analyze and discuss further the "duty to treat."

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CASE

This case took place in the early spring of 2003 in Toronto, Canada, during the SARS outbreak. This is a true case, detailed by the physician who was affected in the *Canadian Medical Association Journal*.[2]

Dr. C. M. Cheung was caring for patients on the SARS ward in hospital. He was following the prescribed protocols and using appropriate protective masks and garments. Despite these precautions, 72 hours after initial contact with his patients, he felt warm and uncomfortable with a slight fever.

When his temperature reached 39°C, he called the infectious disease consultant and was given a next-day appointment. At that time, Dr. Cheung was seen in the SARS assessment room. His CBC results were normal, but he was found to have a slightly elevated glucose level. The chest film looked suspicious, and the CT scan showed a lingular infiltrate. SARS was diagnosed, and Dr. Cheung was admitted to hospital and treated with ribavirin and prednisone.

During the next few days, Dr. Cheung experienced lymphopenia, thrombocytopenia, and rising lactate dehydrogenase levels. The ribavirin used to treat him caused severe nausea. He was treated with methylprednisolone, 500 mg daily for 3 days, and the dosage was then tapered to 50 mg daily. His fever persisted, however, and on day 11 his breathing started to deteriorate, so he was put on supplemental oxygen.

The attending physician was concerned that the rapid tapering of the corticosteroid was contributing to the respiratory distress. He ordered 125 mg of methylprednisolone. The respiratory distress resolved within the hour, and the patient was finally able to sleep well. He recovered slowly, and by day 24 his temperature had dropped to 37°C. Dr. Cheung was discharged to mandatory quarantine for 30 days, after which time he returned to work at the hospital.

CONTACT US

Do you have an ethical quandary?

In future installments of this department, the editor wants to address the real-world ethics concerns and problems of PAs. These might include problems in practice that may be inconspicuous, problems related to systems of care, problems related to the process of care, and preventive ethics.

Please e-mail your ethics question to jaapa@aapa.org. We will consider it for discussion in a future installment of PA Quandaries

THE ETHICAL QUANDARY

One question that seems apparent from Dr. Cheung's story is, when does the duty to treat stop? When is it an expected part of practice? When does it constitute extraordinary care? When does it move into the sphere of heroism? And when does it become martyrdom and excessive suffering for the cause of medicine?

Another haunting issue in this case is expressed best by Dr. Cheung: "[I was] worrying about my family as the fever mounted. Had I infected my wife? Who would look after my children if she became ill? What if the children became infected? I would not want to survive only to know that I had caused the death of a loved one in my immediate family."[2]

DISCUSSION

The acceptance of duty to treat in western medicine dates from the time

of Hippocrates, but in recent years the concept has seemed to have less immediate implications. Indeed, in the latter half of the 20th century, the issue of duty to treat in epidemics appeared to have become a thing of the past.[3] In the late 1950s, vaccines were developed; and in 1977, the Surgeon General said that he believed it was time to "close the book" on infectious disease. Five years later, preparations began to celebrate "an end to smallpox."

Then in the early 1980s, the growing HIV epidemic once more brought into focus the quandary of the duty to treat. The fear of becoming infected with the AIDS virus was fairly widespread within the medical community, and some HIV-positive patients began to have difficulty finding necessary medical care.

In 1987, the Council on Ethical and Judicial Affairs of the American Medical Association (AMA) stated: "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 for HIV. Persons who are seropositive should not be subjected to discrimination based on fear or prejudice."[4] This pronouncement by the AMA addressed in a very general manner the duty to treat, or at least to not discriminate.

ENDANGERING ONESELF During the SARS epidemic of 2003, 45% of those people infected in Toronto were health care workers. In Taiwan, the rate of health workers infected was even higher at 95%.[5] In 1995, 50% of the emergency department personnel in Tokyo became ill from cross-contamination after the sarin gas attack.[6] Concern has been increasing about the health problems developing among first responders who worked at the World Trade Center site after September 11, 2001.[7]

Although these are examples of extreme occurrences, they bring to light the question of whether there is necessarily a limit to our responsibility as health care personnel to care for patients who put us at risk. If there is, how would such a limit be determined? Who makes the decision? Dr. Mathew Wynia, Director of the Institute for Ethics at the AMA, has written extensively about duty to treat during public health emergencies. He suggests considering three dynamics when discussing limits on duty to treat.[3,8–10] These are (1) the need to continue caring for others; (2) reliance; and (3) agreement to take excess risk.

The need to discontinue care arises when the risk of caring for one single patient would lead to the inability to care for others. Reliance suggests that the more specialized knowledge one has and the more others rely on it, the greater the moral obligation to provide care. An agreement to take excess risk can be made more explicit before a crisis occurs, and with increased specialized training, the obligation to treat is greater.

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SOCIETAL RESPONSIBILITIES In the modern western world, society has a shared responsibility to medical providers when duty to treat is the obligation. Four areas of accountability have been suggested. Communities should (1) take all reasonable precautions to prevent illness among health care workers and their families; (2) provide for the care of those who do become ill; (3) reduce or eliminate malpractice threats for those working in high-risk emergency situations; and (4) provide reliable compensation for the families of those who die [or are injured] while fulfilling the duty to treat.[3] These principles of societal obligation ought to be championed by individuals, professional and medical societies, and elected state and federal representatives.

Some final thoughts on duty to treat are expressed by Huber and Wynia. I hope they will generate further discussion within the physician assistant profession and academic community:

> *While deciding on one's professional ethics is necessarily individual, it is not entirely personal—after all, patients must assume that all physicians [and physician assistants] adhere to certain core ethical beliefs. Consideration of this emotionally charged ethical obligation ahead of time will aid in the development of a professional identity and reduce the tendency to appeal to personal morality (or self interest) to intuit one's way through difficult professional situations. Finally, the profession should recognize that there may be a penalty for failure to collectively reaffirm duty. Put simply, contemporary society expects a unified professional identity from its medical practitioners, including acceptance of the duty to treat; in absence of such professionalism, both care for patients in crisis and medicine's claim to exclusive power in society might crumble as the profession fragments.*[3] JAAPA

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