

Clinical Decision Making during Public Health Emergencies: Ethical Considerations

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Recent public health emergencies involving anthrax, the severe acute respiratory syndrome (SARS), and shortages of influenza vaccine have dramatized the need for restrictive public health measures such as quarantine, isolation, and rationing. Front-line physicians will face ethical dilemmas during public health emergencies when patients disagree with these measures. Patients might request interventions that are not recommended or for which they are not eligible, or they might object to intrusive or restrictive measures. The physician's primary responsibility in such emergencies is to the public rather than to the individual patient. In public health emergencies, physicians need to address the pa-

tient's needs and concerns, recognize their changed roles, and work closely with public health officials. Physicians can still work on behalf of patients by advocating for changes in policies and exceptions when warranted and by mitigating the adverse consequences of public health measures. Before an emergency occurs, physicians should think through how they will respond to foreseeable dilemmas arising when patients disagree with public health recommendations.

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Recent public health emergencies involving anthrax, the severe acute respiratory syndrome (SARS), and shortages of influenza vaccine have dramatized the need for such public health measures as outbreak investigations, contact tracing, quarantine, isolation, and rationing. On the public policy level, the justifications for restrictive public health measures have been discussed extensively (1–5). However, less attention has been given to clinical dilemmas that front-line physicians will face during public health emergencies when patients disagree with public health measures. Two different scenarios may arise: Patients might request interventions that are not recommended or for which they are not eligible, or they might object to public health measures. Clinicians need to consider how they would respond to such scenarios in future public health emergencies.

In this paper, we analyze 2 hypothetical cases that illustrate such disagreements. In both, the physician's primary responsibility is to the public rather than the individual patient. We recommend that in public health emergencies, physicians address the patient's needs and concerns, recognize their changed roles, work closely with public health officials, and act in the best interests of patients to the extent possible. Physicians can still work on behalf of patients by advocating for exceptions and changes in policies and by mitigating the adverse consequences of public health measures.

HOW DOES PUBLIC HEALTH DIFFER FROM CLINICAL MEDICINE?

In clinical medicine, physicians promote the best interests of individual patients and respect their autonomy (6, 7). In contrast, public health focuses on the best interests of the population as a whole rather than on the interests of the individual patient (1, 2). Under some circumstances, the liberty and autonomy of the individual patient may be overridden for the good of the public. In response

to a serious, probable threat to the public, it may be appropriate for public health officials to impose mandatory testing, treatment, vaccination, quarantine, or isolation. In addition, public health officials may restrict access to vaccines or drugs that are in short supply.

Recent treatises and articles have set forth criteria that must be satisfied to justify compulsory public health interventions (1–5). The intervention must be *necessary and effective*; that is, the public health threat must be serious and likely, and there must be a sound scientific basis for the intervention. The intervention should be the *least restrictive alternative* that will effectively respond to the threat. There should be *procedural due process* that offers persons deprived of their freedom the right to appeal. Furthermore, the benefits and burdens of intervention should be *fairly distributed* in society, consistent with the epidemiologic features of the threat. Even the perception that some groups are being treated unfairly or are receiving preferential treatment will undermine public support for compulsory measures. Finally, there should be *transparency*. Public health officials should make decisions in an open and accountable manner.

Public health policies in an emergency fall within the authority of public health officials, not individual clinicians. If doctors have questions or disagreements, they should raise their concerns to public health officials instead of taking it upon themselves to override guidelines. Generally, public health officials welcome input from front-line clinicians, particularly with new threats for which knowledge and policies are evolving.

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enforce public health regulations, they generally prefer voluntary measures and resort to mandatory ones only as a last resort. Full compliance with public health measures usually is not necessary to control an outbreak (8). Moreover, mandatory measures have costs and adverse consequences. They may divert limited resources, cause confrontation with patients, and undermine public cooperation. Public health investigations require the cooperation of affected persons to identify contacts and provide information. Voluntary measures generally promote cooperation more than do mandatory ones.

From the perspective of clinicians, strict enforcement of public health measures may also be problematic. In routine public health practice, mandatory reporting of certain diseases, such as seizures and AIDS, may not be strictly enforced. Reporting to public health officials by physicians may compromise the physician–patient relationship, particularly if reporting is controversial or leads to restrictions on the patient’s freedom, such as the right to drive. Fears about such public health measures may deter patients from seeking needed care or returning for follow-up.

REQUESTS FOR INTERVENTIONS NOT RECOMMENDED IN PUBLIC HEALTH GUIDELINES

Case 1: Patient Who Requests Immunization

During the fall of 2004, a 58-year-old man with no chronic medical condition requests an influenza immunization, as he does every year. However, this year there is a severe shortage of vaccine because of the closure of a major manufacturing plant. The physician explains that only patients at highest risk for complications from influenza are eligible for vaccination this year. The patient responds, “Every year you tell me I should get a flu shot. Even with the shot, I usually get a bad case of bronchitis that puts me at home for a week. I worry that if I get a bad case of the flu, I could die. Can’t you just say that I have chronic lung disease, so I can get the shot?”

This case dramatizes how public health emergencies differ from ordinary clinical practice. In this case, the patient requests an intervention that is recommended by evidence-based practice guidelines. However, because of a severe shortage of vaccine, the Centers for Disease Control and Prevention and local health departments established prioritization criteria to ensure that patients at greatest risk received the limited supply (9). Patients who ordinarily would be urged to get immunized, such as healthy persons older than 50 years of age, were not eligible. Moreover, no alternatives were available for season-long prophylaxis; intranasal live attenuated influenza vaccine is not approved by the U.S. Food and Drug Administration for persons older than 50 years of age. Thus, individual patients were denied an effective and cost-effective intervention in order to help persons at greater risk. California and other jurisdictions declared a public health emergency and ordered health care providers to limit vaccinations to patients in designated high-priority categories (10, 11). Under such an

emergency declaration, public health officials have the authority to buy unused stocks of vaccine or to seize vaccines from providers who vaccinated persons who were not in the high-priority groups.

In ordinary clinical practice, physicians work as advocates for individual patients, helping them to obtain interventions that are in their best interests. In clinical practice, care to 1 patient usually only indirectly affects third parties—for example, through increased health care costs. In contrast, during a public health emergency, it may not be appropriate or feasible to provide beneficial interventions to persons outside the guidelines.

Address the Patient’s Needs and Concerns

As in any disagreement with patients, physicians should first elicit and address the patient’s concerns and needs. Anxiety, anger, fear, and a feeling of loss of control are natural reactions to an emergency. Furthermore, physicians should acknowledge the uncertainty inherent in a situation in which knowledge is evolving. Doctors can use empathic comments to encourage patients to explore their emotions and to normalize them. Trying to reassure patients simply by telling them not to worry is unlikely to be effective. It is reasonable for someone to be worried about not receiving a beneficial medical intervention. Patients may be more willing to consider the public health implications of their decision after their own concerns are acknowledged.

Protect the Public Health

In public health emergencies, physicians’ responsibilities to the common good supersede responsibilities to individual patients. Unlike in ordinary clinical practice, making a decision for one patient may significantly affect the spread of an epidemic, public trust, and perceptions of fairness. Case 1 involved an absolute shortage of vaccine rather than merely concerns about cost. Providing immunizations to persons at low priority might make them unavailable to those at greatest risk. Furthermore, in an emergency, exceptions to guidelines are likely to be publicized, leading to a perception that the guidelines are being unfairly implemented or that the threat differs from what officials acknowledge. As a result, trust in public health officials and policies may be undermined.

Act in the Best Interests of the Patient to the Extent Possible

In a public health emergency, physicians should maintain their usual role of acting in the best interests of the patient to the extent possible. Physicians can build on their experience with other disagreements with patients and other public health situations.

Maintain the Physician–Patient Relationship

Ongoing contact with patients is particularly important during a public health emergency. As more knowledge is gained about the epidemic, recommendations for pre-

vention and treatment may be modified. Criteria for immunization were broadened several times after existing supplies of vaccine were not fully used by high-priority groups, and additional vaccine was obtained (12, 13). In case 1, the patient may be reassured if he knows he will be recontacted if vaccine becomes available.

After acknowledging the patient's personal concerns, the doctor can then explain why the patient has a personal stake in a fair distribution system—as do all members of the public. The patient's family or friends may be in groups recommended to receive the vaccine.

Set Limits Clearly

Physicians should tell patients if they have no discretion over public health orders. In case 1, the physician should state clearly that she and other providers cannot give the vaccine as requested this year.

To circumvent limits, some patients may ask doctors to misrepresent their condition. For instance, the patient in case 1 requests that the doctor say he has a chronic condition to justify the immunization. Some physicians may believe that it is acceptable to misrepresent a patient's condition to a health insurance plan to obtain coverage for needed services (14, 15). However, it is ethically problematic for doctors to deceive third parties on behalf of patients (16). If doctors use deception in one situation, neither their own patients nor the public can trust them to be truthful in other situations. In public health emergencies, the public needs to trust that doctors accept public health measures and are implementing them fairly. Furthermore, one deception is likely to create a web of complications that might necessitate further deception (17). If the doctor says that the patient has a chronic medical condition, she could be asked to name the condition or provide documentation.

REFUSAL OF PUBLIC HEALTH INTERVENTIONS

Case 2: Patient Who Rejects Quarantine

During the SARS epidemic in 2002, a 48-year-old businessman presents with fever, cough, and malaise. Five days earlier, he returned from a trip to a country where SARS cases have been reported, but he was not near any SARS-affected areas. He says his symptoms are no different from what he commonly experiences after such long travel. Because SARS cases have been reported in your city, public health officials are requiring physicians to report such cases for consideration of home quarantine. He objects strongly. "If I had known that, I wouldn't have come in. I have a lot of meetings that I can't do over the phone. My business would go down the tubes if I were quarantined."

In clinical practice, when patients refuse recommended interventions, their informed wishes are respected. However, in public health emergencies, individual autonomy is not paramount. Compulsory measures such as quarantine and isolation may be imposed to prevent trans-

mission to others and to control an outbreak of a serious infection.

Address the Patient's Needs and Concerns

Physicians should acknowledge that quarantine or isolation entails hardships. Persons in home isolation and quarantine experience difficulties with shopping for food and other necessities; inability to care for children and other dependents; economic setbacks from lost income; and emotions such as anxiety, anger, fear, loss of control, and loneliness (18–20).

Protect the Public Health

The starting presumption in public health emergencies is that physicians should follow public health guidelines. Exceptions need to be carefully justified, as we later discuss. Inconsistent implementation of public health guidelines fosters perceptions of unfairness and suggests that the threat is not as serious as officials claim.

Set Limits Clearly

Physicians need to be clear about the limits of their discretion. In an emergency, doctors need to report cases to public health officials despite the patient's objections. Infections may be reported directly by hospitals or clinical laboratories rather than individual physicians. In some situations, isolation and quarantine may be voluntary rather than mandatory (5); if this is true in case 2, physicians may use their discretion.

Establish Common Ground with Patients

Most patients who reject public health measures do not want to infect others. In addition, businesspeople may harm their reputation and business relationships if they refuse public health measures and others are infected as a result. Furthermore, cooperating with public health officials may provide access to special tests that are not otherwise available.

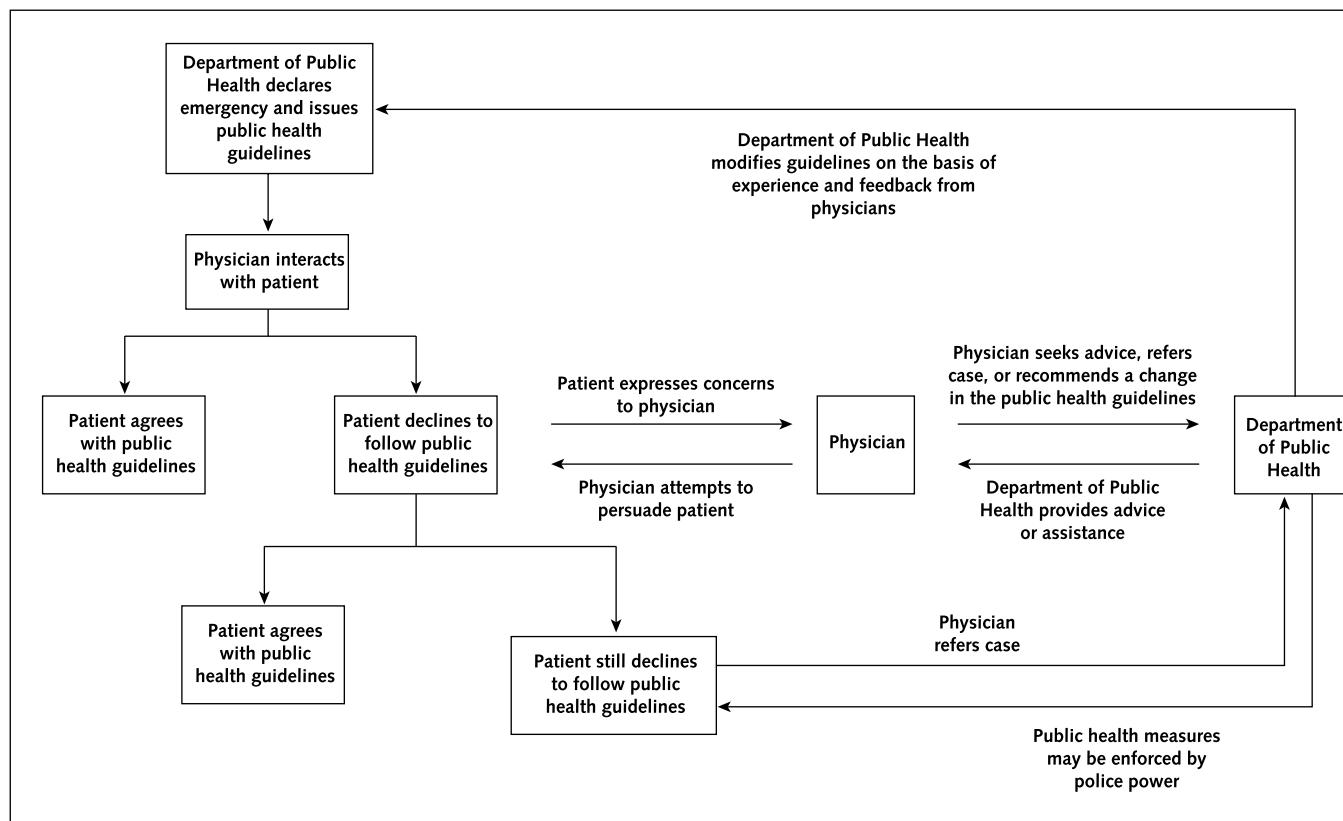
Act in the Best Interests of the Patient to the Extent Ethically Appropriate

Advocate on Behalf of Patients

Doctors should advocate on behalf of patients for changes in guidelines or exceptions that they believe are justified. In an emergency, public health recommendations are made under uncertainty and time constraints. Public health officials cannot foresee all pertinent considerations and all situations. Guidelines will change over time as knowledge about the outbreak grows and its trajectory becomes clear. Hence, a particular case may be a justified exception to public health policies or may show that a policy should be modified. For example, quarantine of all symptomatic persons who have traveled to a particular country may not be justified if cases of the disease have been reported only from a well-defined area of a large country. Of course, the details of the patient's travel history and current symptoms would also be pertinent.

Advocacy does not mean trying to obtain whatever the patient wants (21). Instead, physicians should seek an ex-

Figure. Physician responses when patients disagree with public health guidelines in an emergency.



ception or change in guidelines only when there are principled reasons to support it. The ethical principle of justice requires that similar cases be treated similarly, while cases that differ in ethically pertinent ways should be treated differently (22). Physicians who urge an exception for a particular patient should also be willing to support an exception for other similar patients. If such a widespread exception would not be feasible or justified, it would be unfair to make an exception for an individual patient. Only ethically pertinent considerations should be taken into account; the risk for disease is certainly relevant, but economic hardships are not. It would not be ethically persuasive to argue that patients who might suffer great economic losses should be exempted from home quarantine.

Mitigate the Adverse Consequences of Public Health Restrictions

As previously noted, persons in isolation or quarantine experience a range of economic and practical problems. Although most of these problems fall outside the physician's expertise and control, the doctor can help patients obtain needed services by referring them to appropriate social service agencies. The doctor can also advocate for programs to address such needs. Furthermore, the physician can provide emotional support to these patients through telephone or e-mail conversations. In other situations, patients appreciate that their physician is present for

them, even though the doctor cannot change the objective situation.

RECOMMENDATIONS

Although it is impossible to predict what specific disagreements may occur with future emergency public health measures, several general principles should help physicians resolve them (Figure).

Build on Clinical Experience and Skills

The traditional tools of the physician–patient relationship—eliciting and responding to patient concerns, providing ongoing care, listening with empathy, and simply being available—can be therapeutic because patients feel that someone understands them and cares about them (23–26). Doctors can help patients to cope with the emergency even if they cannot fulfill the patient's requests or change the underlying situation (27).

Recognize the Changed Role of Physicians in Public Health Emergencies

Although caring for patients in public health emergencies is similar to ordinary patient care in many ways, there are also crucial differences. As noted, physicians' primary ethical responsibility in a public health emergency is the well-being of the public, not the interests of the individual patient. Physicians need to be clear in their own minds about their altered responsibilities, the heightened public

scrutiny of their decisions, and the importance of perceptions of fairness. In addition, physicians also need to explain to patients both the changes and continuities in their role. Front-line physicians play an important role in conveying to the public that emergency public health measures are necessary and fair.

Work Closely with Public Health Officials

Although public health officials and practicing physicians have different perspectives and roles, they can and should work closely during public health emergencies (Figure). Physicians in practice should seek advice from public health officials when they cannot persuade patients to accept public health guidelines. Often, experienced public health officers can offer constructive suggestions on how to talk with nonadherent patients. In some cases, public health officials may take over discussions with patients who refuse emergency public health measures or may decide to enforce public health guidelines using police powers. Officials also may be able to provide social services to patients subjected to public health measures such as quarantine.

Officials can enforce restrictive public health measures in ways that support the physician–patient relationship. If SARS is diagnosed in a hospitalized patient, responsibility for reporting the case can be placed on the hospital, not the patient’s personal physician. From a public health perspective, it may suffice to enforce reporting only of hospital-based cases. Stringent reporting of office-based possible cases may be low-yield and may be taxing on physician–patient relationships. In an emergency, public health officials should promulgate only restrictive measures that are essential to public health objectives and that they will vigorously enforce.

Public health officials also should give a clear public message that the situation is a true emergency and that compliance with public health restrictions is needed. They also can acknowledge the hardships of restrictive measures, assure that the least restrictive measures are being used, and appeal to a sense of civic responsibility. Officials can take advantage of the intense media exposure that occurs during public health emergencies.

The questions, concerns, and objections of practicing physicians should be of great interest to public health officials. These officials have the responsibility for making timely policy decisions but may not address particular situations. Hearing from front-line physicians may help them improve or change existing policies. Ideally, there should be some mechanism for officials to communicate regularly with physicians on the front lines of the epidemic—for example, through meetings with the local medical society board.

CONCLUSION

In public health emergencies, the time for physicians to deliberate about a particular case may be limited. Before a crisis occurs, physicians should think through how they

will respond to dilemmas arising when patients disagree with public health recommendations or requirements. Physicians can still act in the best interests of their patients within the limits posed by emergency public health orders.

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