A framework for an obligation to care

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"A profession is characterized by a specialized body of knowledge that its members must teach and expand, a code of ethics and duty of service that put patient care above self-interest and by the privilege of self-regulation granted by society. " (1) This definition describes the professionalism at the core of the practice of medicine but also provides a useful framework for an obligation to provide care. This discussion will focus on the challenges faced by physicians and other health care professionals to provide care for sick persons as the roles of providers, patients, payers and health care systems are evolving. The basis for this obligation can be considered from several viewpoints such as the ethical principles, historical roots, legality, professionalism and social mores. New models of care including team based systems, a more patient-centered approach and increased responsibility of patients in their own care need additional consideration.

What is the physician's obligation to care? Can a physician refuse to treat a patient? While history does not present a consistent tradition of duty to care, the moral obligation of physicians is well described in early Greek, Chinese, Islamic and other world traditions. In Europe, cataclysmic events such as the bubonic plaque in 14th century brought shifts in societal expectations that physicians would care for the sick even when placing themselves at personal risk. Though not without controversy, this obligation was reiterated in the United States with the yellow fever epidemic in 1793, AIDs in 1980, the events of September 11 in 2001 and in Canada with SARs in 2003. Upon further examination of physician obligation there are several factors at play. US law does not recognize medicine as a moral enterprise but a contractual arrangement with obligations that prohibit abandonment and refusal to treat on basis of disability. Society has a contract with physicians. The privilege bestowed from recognizing their professional status, self-regulation, subsidized education and monopolistic licenses obligates their providing care for the sick. Professional Societies developed codes in Europe and US in 19th century that exhorted the primacy of patient welfare and described denial of care as unethical.

Beyond the legal and social framework there are more personal motivations to consider. Ethical principles of doing good, doing no harm, fair distribution of finite resources and the primacy of patient welfare provide the ethical basis for duty to care. Medicine as a profession is seen as a moral enterprise because of its altruistic mission to care for patients. "Altruism contributes to the trust that is central to the patient-physician relationship. Market forces, societal pressures and administrative exigencies must not compromise this principle." (2) Personal beliefs predetermine that those choosing medicine as a profession see the physician as being guided by doing good (beneficence) and doing right (virtue). On the other hand, physician discretion allows that there is no absolute obligation for one physician to care for every person in need nor every need of an individual patient. Physicians thus choose whom to or not to treat. Reasons for not treating include lack of physician competence in a particular area of practice, moral or

religious objections, undue risk to patient or physician from the other, perceived patient hostility, physician or institution having no space or time. As reasons for refusal may be more or less legitimate, the primacy of patient welfare should be the determining factor in decisions about both individuals and groups of patients.

New challenges to a physician's obligation to treat individual patients include fragmentation of responsibility as patients are treated by multiple providers, specialists and subspecialists both in and out of hospitals, physician work hours that are controlled by regulations and institutions not by the individual physician, payment that is linked to volume or quality of care, patient knowledge and autonomy challenging physician authority and lack of workforce and financial resources that limit access to care for individual patients and populations.

New models of care that rely on teams of providers rather than individual physicians such as the patient centered medical home and neighborhood (PCMHN) as well as evolving partnerships with patients that encourage shared responsibility can provide solutions to ensure that individual physicians and the profession can fulfill their obligation to provide care for those in need. However issues within these models may not be adequately addressed by our current ethical framework.

To ensure that those in need are not refused care we must revise codes, polices and laws where needed; ensure that new models of care have a sound ethical framework and that policy is developed by weighting ethical, medical and economic factors to ensure equitable distribution of resources.

(1) ACP Ethics Manual Fifth Edition, *Ann Intern Med April 5, 2005 142:560-582*
(2) Medical Professionalism in the New Millennium: A Physician Charter, *Ann Intern Med, 2002, 136:243-246*