

SYMPOSIUM

Of Epidemic Proportions: Physicians, Personal Risk, and Public Trust

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INTRODUCTION

Dr. Carlo Urbani was the first person to recognize Severe Acute Respiratory Syndrome (SARS) in a Hanoi, Vietnam, hospital. On March 29, 2003, only one month after the discovery, Dr. Urbani died from the disease, largely because of his belief that it is a doctor's duty to "stay close to the victims." His wife, Giuliani, mother of three, challenged her husband on the point; Dr. Urbani replied, "If I can't work in such situations, what am I here for?" With the question of avian epidemics (indeed pandemics) looming ahead, we might well consider the extent of risk that is incumbent in the physician's role when facing such contagious populations. While the level of risk embraced by Dr. Urbani far exceeds what I believe should be expected, I will show, nonetheless, there is a general duty to treat at a professionally appropriate level of risk grounded in natural moral obligations and the medical profession's reciprocal standing as a public trust.

SKETCHING THE ARGUMENT

In an essay titled "In Harm's Way: AMA Physicians and the Duty to Treat," [1], I argued that a physician's duty to

treat, at personal risk, followed not only from the language, history, and precedents of the American Medical Association's Code of Ethics, but that the argument was sound in morally relevant ways. The present essay borrows substantially from that argument, but it will be argued further that the duty not only enlists fiduciary and contractual features of a professional public trust, but there are natural aspects of the obligation to assist that bind us all. The claim will be that our natural obligations are elevated if there are enhanced capacities to render aid, particularly in times of critical need.

The natural aspects of an obligation to assist arise in medical contexts from our natural vulnerability to illness and disease. Principles of justice indicate that asymmetries in natural vulnerability, if they can be adjusted, ought to be adjusted in reasonable terms among competing obligations and considerations. As medical science has developed greater measures to ameliorate and cure illness, the duty to deploy such measures has accrued greater moral dimensions, which, of course, requires that there are persons competent to make such measures available. Since the medical profession is thus distinctively situated to dispense needed medical care, there fol-

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lows a *prima facie* obligation for the profession to deploy those measures.

The duty to assist is also capaciously founded in the special contractual features that flow from an implicit social covenant grounded in the profession's standing as a public trust. According to this covenant, the profession has negotiated and committed itself to a social arrangement that is neither market-based nor politically driven. It is a relationship whereby the profession assumes a fiduciary obligation to care for the medical well-being of persons before considerations of profits or politics. The point being that persons — as patients — are to be regarded as logically prior to other interests and concerns, though not independent of such concerns. Crucially, this priority is held as a relationship of public trust rather than one that is legally crafted or defined.

All this is not to say that the medical profession, as public trust, does not have essential economic and political dimensions. What it does indicate is that when these factors cannot readily be reconciled within the patient-centered perspective, the patient-based priority must visibly trump other competing interests and concerns. In such conflicts of professional obligations, the compact of trust comes into full public witness. During such times, especially, the profession is required to publicly reinforce its self-proclaimed true North. Public confidence that the medical profession can be trusted to cleave to patient care, above all else, is the moral center of the profession.

One noteworthy aspect of this analysis is that while physicians, nurses, and other medical professionals are thus recognized as stewards of this trust, it must be acknowledged that since physicians have been the primary recipients of the socially bestowed advantages and benefits, physicians thereby carry greater burdens of social responsibility — *Noblesse oblige*.

This scheme of medical obligations might seem a bit lofty to some, but there are real world terms that have kept this

trust in place. As indicated, in return for maintaining the priority of patients, the profession has been remunerated with a public largess of professional autonomy and the attendant goods that flow from such standing. Principal among those goods are control over one's work, high social status, and sizable income. [2] The duty can perhaps be schematized as following from five distinct "Cs": covenant, consent, contract, compensation, and capability.

As to the capability portion of the argument, the treatment follows an argument to be elaborated later derived from Judith Jarvis Thomson.[3] The point being that during times of critical need, and in the absence of overriding complications or burdens, we all have the duty to assist if we have the capacity to render it. However, duties to assist are ratcheted up by increased capacity to render crucially needed aid. Other things being equal, a trained lifeguard, whether working in that role or not, has a greater moral duty to assist a swimmer in trouble than the average bather on the beach. The knowledge and skills possessed by persons trained in lifesaving not only make it more feasible to assist in effective ways, but the same lifesaving skills also help to protect the lifeguard from pitfalls to which the untrained are more apt to fall victim.

The overall argument concludes thus that beyond the natural obligation to assist, the person-based features of the medical profession, as public trust, along with the knowledge and skills available as part of the profession, casts members of the profession into a role similar to social lifeguards, especially during times of critical medical need.

BACKGROUND TO THE DUTY TO TREAT

Our question regarding personal risk was famously addressed by the American Medical Association with the publication of the first AMA Code of Ethics in 1847. The concern that prompted talk of person-

al risk was the presence of pestilence and the threat of impending epidemics. The expression of this duty was rendered in bold and unequivocal terms.

When pestilence prevails, it is [physicians'] duty to face the danger, and continue their labors for the alleviation of suffering, even at the jeopardy of their own lives.[4]

Of course, pestilence wasn't anything new to human history. But surprising to many is the fact that in the broad sweep of medical history, from Greece and Rome to modern times, no consistent professional tradition could be identified regarding physicians and personal risk when pestilence did prevail. Indeed, when faced with contagious populations, many famous physicians, including Galen, fled for their lives. Hence, the declaration made by the AMA, in 1847, was at once dramatic and professionally defining. In an essay by Zuger and Miles, it is noted that since 1847, the AMA's bold move to embrace a policy of personal risk during public perils has had sustained effects.

In the history of ethical codes for the medical profession, this statement is unprecedented ... The AMA's strong statement probably owes more to a determination to establish the honor and prestige of the profession than to physicians' actual abilities ... Still, the sense of duty formalized by the AMA was sustained ... it becomes far more difficult to find recorded instances of physicians' reluctance to accept the risks that epidemics entailed for them.[5]

It is interesting to note that after 1957, the language of personal risk disappears from the AMA Code without argument or explanation.[6] Huber and Wynia argue that since the language of accepting personal risk was largely crafted as a response to the threat of pestilence, it disappeared thus, because the threat no longer seemed to be a serious danger. What happened, they write, was that "by the 1950s, the era of massive epidemics was perceived to be ending in America." [7] They further note that statements on epidemics were quietly

withdrawn in 1977 as "irrelevant 'historical anachronisms'" [8].

Largely due to the terrorist events surrounding September 11, 2001, the language of responding at personal risk returned to the AMA literature in December 2001, when the House of Delegates of the AMA adopted a "Social Contract with Humanity" that contained a Declaration of Professional Responsibility.[9] The key portion of the Declaration reads as follows:

"We, the members of the world community of physicians, solemnly commit ourselves to:

4. Apply our knowledge and skills when needed, though doing so may put us at risk." [10]

The crucial years for the duty to treat at personal risk arose thus after AMA's proclamation of 1847. While it was in this year that the duty was first articulated, the obligation cannot be argued to gain social legitimacy until the profession itself assumes a clear and commanding position within the social order. Let us briefly turn to this question.

After the turn of the 19th century, the unfolding of the profession's social position took a distinctive turn and the issue received important analysis and elaboration in Paul Starr's Pulitzer Prize-winning book, *The Social Transformation of American Medicine*. [11] In this book, Starr refers to the medical profession in the United States as the "sovereign profession" and ultimately locates the key to the profession's transformation in its acquisition of social authority. While the most influential single explanation for the ascendancy of American medicine can be found with the rise of medical science, Starr is quick to qualify this by noting that if it was science alone, things easily might have gone in another direction. Indeed, rather than elevating medicine into professional sovereignty, "[t]he growth of science might have reduced professional autonomy by making doctors dependent upon organizations." [12]

For the profession to succeed in the way it has, the profession has had to persuade the public not only that it has the scientifically grounded capacity and competence to address the concerns of patients and the public, but that it will faithfully address those concerns — as a fiduciary — in recognition of the reciprocal terms of a public trust. This fiduciary posture at once distances the profession from the norms of free market competition, and its reigning ethos of *caveat emptor*, and also spikes the view that the medical profession simply functions as a monopolistic power elite that has self-servingly driven its way into social control. Starr puts the point this way:

If the medical profession were merely a monopolistic guild, its position would be much less secure than it is. The basis of its high income and status ... is its authority, which arises from lay deference and institutionalized forms of dependence. The private interests of physicians alone would be insufficient to sway the society had they been unable to satisfy the felt needs of others.[13]

Accordingly, the accomplishment of the medical profession required having established itself publicly as the unchallenged authority for medical matters and as the institution most willing and capable of deploying those skills. Crucially, the notion of “authority” that Starr considers flows from its “classical sense” as that which “signifies the possession of some status, quality, or claim that compels trust or obedience.”[14] Starr furthers the point noting that doctors, as professionals, “...claim authority, not as individuals, but as members of a community that has objectively validated its competence.”[15]

Since I have used the AMA’s Code of Ethics as part of the literature providing strong notice of a duty to treat a personal risk, it might be well to mention some prominent confusions that have arisen in the interpretation of the AMA Code. One source of trouble for our argument comes from Principle VI of the AMA Code, which asserts that:

A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical care.[16]

A casual reading of this principle, when taken out of context, might suggest that “except in emergencies,” AMA physicians have the right to serve wherever and in whatever circumstances they please, and this need not include service during times of epidemics, especially when facing personal risk to themselves. That is, by taking a narrow interpretation of “emergencies” (e.g., bystander cases, emergency room duty), some might think the autonomy rights of AMA physicians actually trump broader public service duties. Such a reading, on its face, seems well out of keeping with the broader spirit of the AMA Code. However, the narrow focus does speak to a libertarian strain that should be give us pause. The narrow construal of “emergencies” must be seen as defensible in some legitimate form if the libertarian interpretation is to sustain itself. Generally speaking, the question is whether AMA physicians should be ethically bound to subordinate their autonomy rights to public needs when faced with the threat of an acute public medical need.

Two distinct matters need to be considered. First is the question of whether societal obligations *ever* trump the autonomy rights of physicians. Second, if they do, does that involve an obligation to assist, even at a physician’s peril? As to the first question, the logic of the principles requires an answer in the affirmative. In an essay from 1996, I took this question to task and concluded that as a matter of logical consistency, the narrow construal can not be sustained.

... if we have included an independent reference to societal obligations and allowed that except in emergencies (narrowly construed) such obligations may be overruled in any case, then in principle, we have allowed physician autonomy to overrule in every case. However, this would render the societal pro-

vision altogether pointless. ... it appears that the narrow construal of emergency would arbitrarily foreclose on the responsibility to society clause. Thus, a close reading of the AMA document reveals a derivable, although indirect constraint on physician autonomy for at least some societal emergencies.[17]

While it might be objected that even under this interpretation a particular physician's autonomy remains free and unconstrained in selecting which societal duties are to be undertaken, it should be understood, nonetheless, that such a consideration arises secondary to the more general principle — of the interpretation — that *some* societal duties must trump physicians' autonomy rights, Principle VI terminology notwithstanding. Once it is allowed that broader societal emergencies sometimes trump physicians' autonomy rights, the question shifts from "whether or not" to questions of "when and to what extent." This analysis leaves the position regarding public service and service at risk as an open question not to be foreclosed even by the narrow reading of Principle VI.

Certainly, more could have been done by the AMA to avoid any predilection to such a narrow interpretation. However, in behalf of the AMA, the newest version of the Code (2001) contains revisions that re-emphasize that "a physician must recognize responsibility to patients first and foremost, as well as to society, to other health professionals, and to self" (Preamble); there is also a phrase asserting the duty to contribute to "the improvement of the community and the betterment of public health" (Principle VII), and that "A physician shall support access to medical care for all people" (Principle IX).

With this array of argument and historical record, the seeming gap that Principle VI leaves open to interpret autonomy rights as a trump over societal obligations looks thin and tenuous indeed. Consistency arguments aside, a pure libertarian reading on Principle VI could now

only hold sway if it was read out of context as something of a loophole clause. Yet even if we ignore the logical point, it needs to be noted that since 1984, any tendency to such a narrow analysis must also fail. In the Preface of the 2002-03 edition of the AMA Code, we read:

No one Principle of Medical Ethics can stand alone or be individually applied to a situation. In all instances, it is the overall intent and influence of the Principles of Medical Ethics, which shall measure ethical behavior for the physician.[18,19]

Clearly then, we are instructed to avoid considering principles in isolation from the companion principles. Individual cases are to be considered by a balance among the principles. So while the declaration and other features of the should not be used to interpret the principles, it remains open to consider the declaration, opinions, and other aspects of the code as a basis to inform our judgment regarding individual cases. The point is usefully compared to what John Rawls has called "considered judgment" within a conception of "reflective equilibrium." For instance, when Rawls speaks of reflective equilibrium, he envisions a situation in which decisions are said to be negotiated in a "... process of mutual adjustment of principles and considered judgements ..."[20] This conception is aimed to bring principles and judgments into a state of greater equilibrium, "after a person has weighed various proposed conceptions and he has either revised his judgments to accord with one of them or held fast to his initial convictions..."[21]

A DUTY TO ASSIST: REALIZING THE RISKS

In 1991, Norman Daniels took up our question of a duty to treat at personal risk in the context of HIV infection and argued for such a duty based on an analysis of "consent." [22] In his analysis, Daniels

considers the AMA's 1847 claim that a physician is expected to treat "without regard to the risk to his own health" an extreme and unrealistic view. He writes, "[w]e must believe that there are some limits, however vaguely specified, to the risks physicians have agreed to face."^[23] Daniels then constructs a basic argument for the duty to treat in terms of what he calls a middle ground or a "modified AMA position." Generally speaking, his argument runs as follows: Since physicians have consented to some (vaguely defined) standard of risk when they enter the profession, if the circumstances (HIV, bioterrorism, etc.) fall under that standard of risk, then there is a duty to treat even at personal risk if the risks fall within that standard. The point of this argument, while it might seem vague, actually aims to settle one point with finality: Namely, is there such a duty or no?

The argument by Daniels appears based on both public and professional understanding of what it means to adopt the physician's role. That public information and understanding of the physician's role is readily available is evident in the long list of medical programs stretching back to Doctor Kildare, Marcus Welby, and Ben Casey. More recently, shows such as *M*A*S*H*, *General Hospital*, *ER*, *Chicago Hope*, *Grey's Anatomy*, *House*, and *Scrubs* have also focused their gaze on various dimensions of the role of doctoring. I take it as uncontroversial, thus, that there is abundant public information regarding the physician's role. The dedication and sacrifice suffered by physicians for the sake of their patients is always a thematic undertone, whether the protagonist lives up to the standard or not, and whether or not such is the explicit subject of the particular episode or show. While Daniels appears to rely on this kind of general understanding of the physician's role, he draws back from endorsing the extreme language of the 1847 code that indicates physicians should accept risks up to and

including the risk of their own lives. Certainly, the idea of physicians risking their lives as a moral duty is aimed much too high to be realistic and, consequently, some discussion of what is meant by acceptable risk is needed.

Alexander and Wynia point out that a variety of arguments have been offered supporting a duty to treat under conditions of personal risk, but they claim, "[e]ach of these arguments has limitations and none can provide specific guidance as to the exact degree of risk to be undertaken. Yet as with other public service professions, including the fire and police forces, risk has traditionally been part of medical care ..."^[24]

While Daniels' argument makes a strong conceptual point, it lacks certain moral and applied considerations that are needed if our goal is to affect behavior and policy. This essay aims at provoking such policy ambitions. As to the moral side of the issue, what is absent in the consent argument is the covenantal character of the medical role. The idea of a covenant harbors greater moral weight than does consent or contract. Consent and contract are well captured by our sense of "rational agreement," but one can consent and contract quite rationally where one does not promise (e.g., think of consenting to work for low wages due to lack of options). Normally, in promising, we do more than agree to follow a certain course of action; we commit ourselves rather to the *rightness* of that course. This promissory quality of the medical role can be seen distinctly in that most well recognized feature of the medical profession: the publicly sworn oath of service to patient care.

As to a more applied focus for our analysis, our primary goal is shifted from a pure theoretical determination of the question to an approach that is designed to achieve consensus and effect recognizable change. Such an applied approach does indeed aim toward philosophical correctness but sets a premium on intermediate

goals of well realized consensus above final correctness. Following this conception of applied ethical analysis, a general standard for rendering aid at personal risk will be articulated. The standard will focus on a conception of a “reasonable physician.” This reasonable physician standard has the practical value of being analogous to the “reasonable person” standard used regularly in tort law as a guide for the jury in determination of the facts regarding cases of alleged negligence. Crucial to the conception is that the reasonable physician is held to possess the virtues of prudence and due care in their decisional capacity.

A second key aspect of the applied analysis is that while persons have natural obligations to assist in “minimally decent” ways, in the face of a critical human need, the standard of aid is largely a function of our power or capacity to assist and our ability to control factors that create personal risk. If having special abilities to assist creates greater obligations to assist, it is particularly true in the case of physicians and the general public. Nonetheless, obligations to “oneself” and to considerations of effectiveness in service can be seen to properly limit physician’s obligations to assist.

CONCEPTUALIZING PROFESSIONAL RISK

An argument to assist in “minimally decent” ways follows an argument noted earlier by Judith Jarvis Thomson. This argument generates a duty to assist from an articulation of the parable of the good Samaritan. Thomson draws our attention to the tragic case of Kitty Genovese and the events that took place on March 13, 1964, in Kew Gardens, Queens. On this day, 38 people watched and did nothing to help as Kitty Genovese was stabbed repeatedly and finally killed. Of the 38 witnesses to her murder, not one person made a phone call to police. Simon,

Powers, and Gunneman also have used this horrible incident as paradigmatic for defining a general “moral minimum” for assisting others in the case of a “critical human need.” The authors note that:

What so deeply disturbed the public’s moral sensibility was that in the face of a critical human need, people who were close to that need and had the power to do something failed to act.[25]

Thomson further considers a three-fold distinction on the notion of Samaritanship. According to Thomson, there are not only good Samaritans, but splendid Samaritans and minimally decent ones as well. Thomson points out that the witnesses to the murder of Kitty Genovese fell below what counts as even minimally decent, and that, she says, is a standard none of us should fall below.

It should be noted that Thomson and Simon, et al., implicitly follow the point made earlier about the contrast between applied ethical analysis and pure theoretical analysis. Thomson’s argument rather obviously steps back from an analysis of “the good” in favor of a broader standard of “minimal decency.” The point by Simon and colleagues parallels Thomson with the goal of a “moral minimum.” This less stringent demand has the advantage of wider agreement and thus greater consensus and policy effectiveness, especially when appeal is made to the reasonable health care professional or physician.

We must appreciate that what counts as minimally decent behavior varies with degree of ability to render aid. If I am trained in water safety and lifesaving, my obligation to assist a drowning victim is greater than the obligation of an untrained citizen. Note, too, that by virtue of such training, personal risk is reduced. Consequently, given the expert knowledge and training of physicians, the minimal standard of rendering aid is higher for physicians, in relevant cases, than the medically unschooled.

So, let us take medical ability and consider the question of personal risk under the standard of “a reasonable physician” along with a standard of “minimal decency.” The reasonable person standard, as articulated in tort law, requires the two virtues of prudence and due care. In light of this, the reasonable physician should realize some minimal acceptance of medically indicated risk as required in the exercise of due care in treating patients.

The combination of factors indicates that members of the medical profession have special obligations to assist and to face some degree of risk beyond the average person in at least three ways. First, since the ability to render aid for physicians is greater, the obligation to assist is also elevated. Second, by consideration of Daniels’ consent argument and our focus on the reasonable physician, we must recognize that by freely joining a profession designed in part to combat disease, a reasonable physician consents to at least some minimal standard of professionally appropriate risk. And third, a reasonable physician, through virtues of prudence and due care, can be expected to realize that the profession — and thus themselves — flourishes due to a social belief that physicians would be available in times of public medical distress. The upshot is that to try to exempt oneself from this obligation, without special reasons, would quite clearly fall afoul of basic injunctions against social “free ridership.” In light of the foregoing, I do not think it amiss to expect that our reasonable physician would concur.

Consequently, if there is a social expectation that the medical profession has an obligation to render aid, even at personal risk, such an expectation cannot be taken lightly by the professional leadership, and especially by our reasonable physician. Indeed, there is a phrase that explicitly captures the point and was continuous in all the AMA codes from 1912 until 1955, allowing that physicians

should be ready to respond to public medical perils “whenever temperate public opinion expects the service.”[26]

RESTRICTING OBLIGATIONS TO PERSONAL RISK

It has been noted that due to expert knowledge and ability, physicians have obligations akin to social lifeguards in times of critical public need. Similarly, during national threats affecting the health and safety of its citizens, such as injuries and illness resulting from terrorism or bioterrorism, physicians carry a higher burden of responsibility than other health professionals and average citizens. Even so, personal risk, when substantial, may exempt us from the obligation to render aid. Our lifeguard would surely be excused from normal life-saving expectations if a drowning victim is seen caught in a strong current that plunges precipitously over a lofty cliff. It is likely that splendid Samaritanship, in such cases, would not only fail to address the critical need, but would tend to compound it. Ill conceived “heroism” tends to undermine actual effectiveness and creates greater harm than good. Following Aristotle, we might say, courage without wisdom quickly tends to rashness.

Since risk is ubiquitous, the issue is one of degree. While decisions will vary according to the situation and individual judgment, it has been noted that special training inherent in the profession should provide a degree of protection not available to the average citizen. Thus, special efforts should be in place to set aside vaccines and other therapies for professionals to ensure that health professionals are able to perform and be protected in their work. The point of protecting the helper first, for optimal effectiveness, is well made by the airline’s recommendation that if oxygen masks are dropped due to a sharp decline in cabin pressure, persons should secure their own masks before acting to assist others.

PUBLIC GOODS AND PUBLIC TRUSTS

Using the analogy of a social lifeguard, my contention has been that the reasonable physician realizes that in the face of infectious epidemics, the role of doctoring is grounded in a public trust that extends beyond care for individual patients to include the public health, especially in times of critical need.

Like our lifeguard, however, personal risk is moderated by professional knowledge and skills. The broader society, for its part, owes the medical profession first access to vaccines and relevant equipment as well as financial support to undertake measures of development. A thorough treatment of the factors that might be included under standards of deployment is beyond the scope of this essay, but clearly there are base line expectations that should be observed under conditions of minimal professionalism. Among those are preparedness to staff hospital facilities, to become educated in the treatment, self-protection, and management of the particular form of virulence, to assist in the diagnosis of actual as opposed to false cases, and to administer anti-anxiety medication when dealing with false and actual cases. The point of such minimal expectations is not to limit behavior, but to provide a clear lower floor standard of acceptability. As ever, some, like Dr. Urbani, will exceed those standards.

As we face growing threats of new, widespread infectious disease, avian H5N1, bioterrorism, and other looming epidemics, the need for the medical profession to respond aggressively is great. My effort has been to argue that by vigorously and wisely addressing this critical need, the medical profession not only provides a crucial public good, but in so doing, it strengthens its professional stewardship and replenishes its social standing in our reciprocally negotiated public trust.

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