Ethical Considerations for Medical Practitioners in Disaster Response in Australia 2008. Revised 2014

1. Preamble

1.1. Public health emergencies can arise from disasters such as natural or man-made disasters, disease pandemics, and terrorist activities.

1.2. A disaster is a serious disruption to community life that overwhelms the innate immediate capacity and resources to cope. It usually requires special mobilisation and organisation of resources other than those normally available to local authorities.¹

1.3. During a disaster, doctors (medical practitioners) and other health care professionals will be called upon to respond by supporting the health care needs of those directly and indirectly affected by the emergency, not only in terms of the immediate (acute) response to the crisis but also in terms of managing any associated long-term health effects in the population.

2. Duty of care during disaster response

2.1. During a disaster, doctors may face difficult ethical dilemmas that do not generally arise during normal clinical practice. While doctors have a duty of care to look after the health and well-being of individual patients, they also have a duty to protect themselves, other patients, staff, colleagues, and the wider public from harm. Further, doctors have a personal interest in protecting their own families from harm.

2.2. Under ‘ordinary’ clinical practice, these multiple duties co-exist harmoniously as the duty to care for individual patients does not generally compete with the duty to protect oneself and others from harm. During a disaster, however, these multiple duties may come into conflict. For example, in ‘ordinary’ clinical circumstances, those who are sickest or most severely injured generally receive treatment first followed by others in order of severity. During a disaster, there may be limited resources immediately available in relation to a large number of sick and/or injured individuals in varying states of health. The doctor has to prioritise which individuals receive treatment over others. This may involve a decision not to actively treat a gravely ill or injured individual who cannot be saved in the specific circumstances of time and place in order to treat others who can be saved.¹

2.3. In addition to protecting others from harm, doctors have a duty to protect themselves from significant harm and should not be expected to exceed the bounds of reasonable personal risk.

3. Supporting the medical profession during and after a disaster response

3.1. Doctors may face personal and professional challenges while responding to a disaster including (but not limited to):
   - greater professional duties;
   - increased occupational risks;
   - physical and emotional stress;
   - isolation from colleagues, family, and friends;
   - risk to their professional liability;
   - loss of income;
   - discrimination and possibly stigmatisation;
   - risk of personal injury, illness, or death; and/or
   - the possibility of exposing family members and others to increased risk of personal illness, injury, or death.
3.2. Employers, governments, and the public have a reciprocal obligation to protect and support doctors responding to a disaster. This includes (but is not limited to):

- protecting the health and well-being of the medical workforce (and their families) during the crisis response;
- providing immediate and ongoing health care and other support, including financial support and psychological care to doctors (and their families) who are harmed or die as a result of the disaster response;
- protecting the privacy of doctors (and their families) (for example, doctors undergoing quarantine during a disease outbreak may face stigmatisation, along with their families, from their community);
- ensuring provisions are made to have affected medical facilities up and running as quickly as possible;
- ensuring the fair and appropriate designation of doctors’ roles and responsibilities; and
- providing doctors with sufficient education, information, guidance, training, and support required to fulfil their duties.

3.3. In order to ensure the medical workforce’s preparedness to respond to a disaster, the medical profession must be involved in the development, implementation, and review of disaster response protocols.

3.4. Such protocols should include standards regarding triage, resource allocation, treatment, and quarantine, as well as consent, privacy, and confidentiality.

3.5. Such protocols should be promulgated to the public so they understand the process, rationale, and justification for clinical decision-making before a disaster actually occurs.

References

See also:

AMA Position Statement on Involvement of GPs in Disaster and Emergency Planning 2012
AMA Position Statement on Supporting GPs in the Aftermath of a Natural Disaster 2012
