MEDICAL ETHICS LECTURE SERIES

Lecture 5

Physician's Duties to Society

Department of Psychiatry • Jordan University Hospital

Psychiatry Residency Training Program

Duration: 40 minutes

LECTURE OVERVIEW

Learning Objectives

- Explain how physician obligations extend beyond the individual patient to society
- Apply the duty to warn/protect identifiable third parties from serious harm
- Discuss resource allocation and justice at the population level
- Describe physician responsibilities during public health emergencies
- Identify physician responsibilities regarding the environment and global health

LET'S BEGIN WITH A SCENARIO

Case Study

CASE VIGNETTE

During an outpatient session, a patient with untreated psychosis describes, in specific detail, a plan to harm a named former employer within the coming days. He asks the resident to keep this "between us." The resident must decide what to do next — and who, if anyone, to tell.

Discussion: Does confidentiality still hold here? What does the resident owe the patient — and what does he owe the person named? Hold this question; we will return to it.

This is the clearest case where a physician's duty extends beyond the individual patient in the room.

WIDENING THE CIRCLE OF DUTY

From Patient to Society

Lectures 1 and 4 focused on duties to the individual patient. But physicians also hold obligations to third parties, communities, and the public — obligations that can sit in real tension with duties to the patient in front of them.[1]

The individual patient

The person currently under a physician's direct care

Identifiable third parties

A specific person placed at risk by information learned in care

The public

Communities and populations affected by disease, policy, or environment

BEYOND THE INDIVIDUAL ENCOUNTER

Public Health: A Collective Responsibility

"Physicians should assist in providing... appropriate education about disease prevention, health promotion... and work with public health authorities to protect the community."[2]

Physicians contribute to public health in everyday practice:

- Health promotion and disease prevention counselling during routine visits
- Surveillance — recognising and reporting patterns relevant to community health
- Supporting evidence-based public health policy with clinical expertise
- Balancing individual patient advocacy with responsibility to the wider population

[2] *WMA Medical Ethics Manual, 3rd ed., Chapter Three — Physicians and Society.*

Duty to Report

Mandatory notifiable diseases

National law designates specific conditions (e.g., tuberculosis, certain STIs) that must be reported to health authorities, regardless of patient preference.

International Health Regulations

WHO member states must report events that may constitute a public health emergency of international concern.[3]

Confidentiality still applies

Reporting is to designated public health authorities, under legal protection — not a general license to disclose.

A narrow, justified exception

This is one of the recognised exceptions to confidentiality introduced in Lecture 2 — defined by law, not physician discretion alone.

WHEN A THIRD PARTY IS AT RISK

The Duty to Warn / Protect

> *"When a therapist determines... that his patient presents a serious danger of violence to another, he incurs an obligation to use reasonable care to protect the intended victim."*[4]

The classic elements that trigger this duty:

- A specific, identifiable victim — or a readily identifiable, foreseeable one
- A credible, serious threat of violence — general anger or vague statements do not meet this threshold
- The physician's clinical judgement that the danger is genuine

[4] *Tarasoff v. Regents of the University of California, 17 Cal.3d 425 (1976) — the case that established this duty in the US and influenced guidance worldwide.*

NOT ALL-OR-NOTHING

Balancing Confidentiality and Public Safety

Protect first, disclose least

Options short of full disclosure — increasing supervision, voluntary hospitalisation — should be considered first where they adequately address the risk.

Warn the specific target

Where warning is necessary, it should go to the identified person and/or law enforcement — not broadcast more widely than needed.

Document the reasoning

Record the clinical basis for judging the threat credible, and the steps taken — protects both patient and physician.

Proportionality throughout

The scope of any disclosure should be no greater than what is necessary to protect the identified person.

JUSTICE AT THE POPULATION LEVEL

Resource Allocation & Justice

The justice principle (Lecture 1) applies not only to individual fairness, but to how scarce health resources are allocated across an entire population.[2]

Bedside allocation

Individual physicians allocate their own time, attention, and immediate resources (e.g., an ICU bed) using clinical criteria.

Institutional allocation

Hospitals and health systems set policies (e.g., triage protocols) that shape resource distribution before an individual case arrives.

Societal allocation

Governments decide overall health budgets and priorities — physicians can and should advocate here, but do not control it directly.

Triage systems are ethical when they use consistent, transparent, clinically justified criteria — not identity, status, or convenience.

Physicians in Public Health Emergencies

A duty to assist — but not an unlimited one

Physicians have an ethical obligation to provide urgent care during disasters, even at greater-than-usual personal risk — but this is not absolute or unbounded.[5]

Triage becomes explicit, not implicit

Scarcity that is usually managed quietly becomes an explicit, system-level decision — requiring transparent, pre-agreed protocols.[6]

Physician safety and wellbeing matter

Institutions are obliged to provide protective equipment and support — physician self-sacrifice is not a substitute for system preparedness.[7]

PREVENTION AS A SOCIETAL DUTY

Vaccination & Preventive Health Advocacy

Physicians play a central role in maintaining population immunity and countering health misinformation — both individually protective and a matter of collective responsibility (herd protection).

What this looks like in practice:

Recommend, don't coerce	Present evidence clearly and address concerns respectfully — individual consent still governs each patient's own decision.
Address misinformation directly	Physicians are uniquely positioned to correct misinformation encountered in clinical encounters.
Advocate at the system level	Support accessible, equitable vaccination programs through professional and institutional channels.

BEYOND NATIONAL BORDERS

Global Health Responsibilities

Health worker migration

Physician emigration can strain health systems in countries of origin — an ethical tension between individual career freedom and systemic impact.[8]

International solidarity

Physicians and national associations are encouraged to support health system strengthening in under-resourced settings.

Cross-border health threats

Infectious disease and health crises do not respect borders — international cooperation is an ethical, not just logistical, necessity.

AN EMERGING, NOW-ESTABLISHED DUTY

Physicians and the Environment

Why this counts as a duty to society

Climate change and pollution are recognised health threats — causing heat-related illness, respiratory disease, and displacement. The WMA holds that physicians have a professional obligation to highlight the health consequences of environmental degradation, not only to treat its effects after the fact.[9]

Practical actions

- Counsel patients on environmental health risks
- Reduce waste in clinical practice where feasible
- Support institutional sustainability efforts
- Advocate through professional associations

Health Advocacy & Policy Engagement

Speak from evidence, not just opinion	Physicians carry particular credibility on health matters — advocacy is most effective, and most ethical, when grounded in evidence.
Engage institutional and professional channels	National medical associations, hospital committees, and professional societies are legitimate, structured avenues for influence.
Advocate for the underserved	Speaking up for populations with limited access to care or political voice is a recognised professional responsibility.
Separate professional and personal	Physicians retain the right to personal political views — clarity about which is being expressed matters, particularly on contested issues.

A PRACTICAL FRAMEWORK

When Individual and Collective Duties Conflict

This is the same underlying reasoning process from Lecture 4 — applied where the 'other party' is society or a third person.

Assess the threshold

here a specific, credible, serious risk – or a general concern that doesn't meet the bar for overriding confidentiality?

Consider less restrictive options

Could increased monitoring, voluntary safeguards, or involving the patient in the plan address the risk first?

Consult before acting alone

Supervisors, ethics resources, or legal counsel can help confirm the threshold is genuinely met.

Act proportionately

Disclose only what is necessary, to only those who need to know, for only as long as needed.

Document thoroughly

Record the reasoning, not just the action — this protects the patient, th third party, and the physician.

RESOLUTION

Back to the Case Study

This threat meets the threshold for action: a specific, named, identifiable victim and a detailed, credible plan. Confidentiality does not hold here — the resident has a duty to protect the identified person.

Applying the framework:

- Consult a supervising psychiatrist immediately — this should not be decided alone as a resident
- Consider whether urgent, voluntary hospitalisation could reduce the risk without external disclosure
- If disclosure is still needed, notify law enforcement and, where appropriate, the identified person
- Document the clinical basis for the assessment and every step taken in response

KEY TAKEAWAYS

Physician's Duties to Society

- Physicians hold obligations beyond the individual patient — to third parties, communities, and the public
- The duty to warn/protect applies to specific, credible, serious threats — not general concern or anger
- Resource allocation decisions should use transparent, clinically justified criteria at every level
- Public health emergencies intensify, but do not eliminate, physicians' rights to safety and support
- When duties conflict, favour the least restrictive, most proportionate, best-documented response

SOURCES CITED IN THIS LECTURE

References

1. World Medical Association. Medical Ethics Manual. 3rd ed., Chapter Three — Physicians and Society. Ferney-Voltaire: WMA; 2015.

2. World Medical Association. Medical Ethics Manual, 3rd ed., Chapter Three, Public Health section.

3. World Health Organization. International Health Regulations (2005), 3rd ed.

4. Tarasoff v. Regents of the University of California, 17 Cal.3d 425 (1976).

5. American Medical Association. AMA Code of Medical Ethics, Opinion 8.3 — Physicians' Responsibilities in Disaster Response and Preparedness.

6. American Medical Association. AMA Code of Medical Ethics, Opinion 11.1.3 — Allocating Limited Health Care Resources.

7. World Medical Association. WMA Statement on Medical Ethics in the Event of Disasters. Adopted 1994; revised 2017.

8. World Medical Association. WMA Statement on Ethical Guidelines for the International Recruitment of Health Personnel.

9. World Medical Association. WMA Declaration of Delhi on Health and Climate Change. Adopted 2009; revised 2017.