Ethical Considerations for Medical Practitioners in Disaster Response in Australia

2022

1. Preamble

1.1 A disaster[1] can cause a serious disruption to community life which can lead to substantial material damage, disruption of essential infrastructure, considerable displacement of people, many victims and significant social disruption. Disasters include disease pandemics and catastrophes such as natural or human-made disasters, can occur over a short or long period of time and can impact geographical areas ranging from small, local settings to larger, more widespread settings that can impact across national as well as international borders.

1.2 Disasters are any sudden disruption that causes widespread human, material, economic or environmental loss which exceeds the ability of the affected community or system to cope using existing resources. Health care is part of a wider disaster response. Disasters require an all hazard and multiagency response including setting up command centers, communication, transportation, food and water supplies, power supplies as well as health and medical services.

1.3 From a medical standpoint, disaster situations are characterised by an acute and unforeseen imbalance between resources and the capacity of medical professionals, and the needs of survivors who are injured or whose health is threatened, over a given period of time.[i] During a disaster, doctors (medical practitioners) and other health care workers will likely be called upon along with other emergency responders to support the health care needs of those directly and indirectly impacted by the disaster.[i]

1.4 During a disaster when resources are overwhelmed, doctors will be faced with ethical challenges that do not generally occur during ordinary clinical encounters. These include rationing of scarce resources, prioritising care to specific patients, withdrawing care and providing basic care rather than comprehensive treatment. This position statement serves to identify a range of those ethical challenges and highlight the major medical professional values and ethical principles that should guide doctors in their disaster response.

2. Professional values and ethical principles in times of disaster

2.1 Doctors have a duty of care to look after the health and well-being of individual patients as well as a duty to protect other patients, staff, colleagues, other health care workers and the wider community from harm. In ordinary clinical conditions, these multiple duties co-exist harmoniously; however, tensions can arise between these duties during a disaster. For example, the disruption caused by a disaster can lead

to the demand for health care resources exceeding the capacity of the health system to provide everyone with the standard of care they would expect to receive in ordinary clinical conditions.

---

[1]The United Nations Office for Disaster Risk Reduction defines disasters as *'a serious disruption of the functioning of a community or a society at any scale due to hazardous events interacting with conditions of exposure, vulnerability and capacity, leading to one or more of the following: human, material, economic and environmental losses and impacts. The effect of the disaster can be immediate and localized, but is often widespread and could last for a long period of time. The effect may test or exceed the capacity of a community or society to cope using its own resources, and therefore may require assistance from external sources, which could include neighbouring jurisdictions, or those at the national or international levels'.* United Nations Office for Disaster Risk Reduction. Terminology. Disaster. https://www.undrr.org/terminology/disaster.

2.2 In addition to balancing their routine professional duties, doctors also have legitimate personal interests in protecting themselves and their own families from harm.

2.3 The disruption and uncertainty often associated with disasters, however, does not justify sidelining the standards of ethical behaviour expected of doctors.[2] The values and ethical principles that guide the medical profession's relationship with patients and the wider community during ordinary clinical circumstances must continue to be upheld during a disaster.

2.4 During a disaster, the following values and ethical principles become particularly relevant:

- maintaining the commitment to, and advocating for, the primacy of patient care, where patients' interests are considered first;
- treating patients with equal respect, compassion and dignity;
- respecting patient autonomy, privacy and confidentiality, to the extent possible;
- treating patients' family members, carers and significant others with respect, recognising that they may also need support;
- advocating for accountability, fairness, equity and justice in the provision of health care and the allocation of health care resources;
- advocating for accountability, fairness, equity and justice in the treatment of the health care workforce and the safety of the health care environment;
- working collaboratively with colleagues and other health care professionals;
- supporting colleagues and other health care professionals during and after a disaster;
- looking after one's own health and well-being, including one's own personal risk of harm, in order to be able to care for others during and following on from a disaster.

2.5 While these ethical values and principles are important for guiding doctors during a disaster, they should also be integrated into disaster planning in order to foster public trust, confidence and acceptance of the disaster response measures in relation to the provision of health care.

3. Disaster planning

3.1 An effective disaster response requires a coordinated, cooperative and collaborative approach between Federal and State governments and relevant agencies. All stakeholders should be familiar with the disaster plan for their organisations, and regular drills should be conducted to test their familiarity with the plan and the system's ability to manage a disaster.

3.2 Federal, State and Territory governments as well as health care facilities must develop and maintain up-to-date disaster plans. These should guide the medical and health care workforce in preparing for, and responding to, such an emergency quickly and efficiently in order to minimise the disaster's impact on the health of the community.

3.3 The development and review of disaster plans should be undertaken in consultation with the medical profession and wider health care workforce to ensure plans are evidence-based, practical, workable, adaptive, responsive and supported by the workforce. For example, doctors will have particular insight into issues of operational efficiency such as addressing surge capacity and use of emergency provider numbers. In addition to Disaster Medicine experts, consultation should include general practitioners and

[2] The AMA *Code of Ethics 2016* articulates and promotes a body of ethical principles to guide doctors' conduct in their relationships with patients, colleagues and society.

other medical specialists in primary and acute care settings in both the private and public health sectors as well as those from rural and remote areas including Indigenous communities.

3.4 It is critical to include local doctors during a disaster response as they are best positioned and skilled to advise on local resources and community needs, particularly in rural and regional areas. For example, in regional areas staff shortages will likely be further exacerbated during a disaster, doctors that are already isolated may not be able to safely proceed as quickly as in other places and some clinicians that are sole practitioners in their specialty may require particular protection from harm.

3.5 Disaster planning should not only address the immediate health effects associated with a disaster but also the associated health effects following on from a disaster, such as increased mental health presentations.

3.6 The development and review of disaster plans should also be undertaken in consultation with the wider public including those from marginalised and vulnerable communities who may already experience health inequalities and may be disproportionately affected by a disaster (eg. Aboriginal and Torres Strait Islander populations, the elderly, disabled individuals, those from culturally and linguistically diverse backgrounds, LGBTQIA+ individuals, those in prison and immigration detention).

3.7 Disaster plans should be:

- understood, supported by, and reflect the values of, the wider community;
- culturally safe and linguistically appropriate;
- accountable, transparent and accessible to the wider community;
- ethically-defensible;
- adaptable to the needs of local communities (based on consultation with local jurisdictions allowing for local flexibility and control);
- dynamic and responsive to rapidly changing circumstances;
- promoted and promulgated to the profession, broader health care workforce and the wider community;
- regularly reviewed and updated with appropriate professional and public consultation.

3.8 Disaster plans should uphold the values of professional autonomy and clinical independence so that doctors can exercise their professional judgement in the care and treatment of their patients without undue or inappropriate influence by third parties. If necessary, an independent body, such as a Clinical Ethics Committee, should be involved in ethical decision making, so that frontline clinicians can focus on provision of care for patients.

3.9 During a disaster, doctors should receive timely, consistent and up-to-date communications on operational and logistical issues such as accessing power, evacuation procedures and identifying pharmacies with emergency powers to provide medications to patients who have lost theirs.

3.10 During a disaster the medical profession must be involved at all levels in planning and disseminating relevant public health messages.

4. The allocation of limited health care resources

4.1 An important challenge that can arise during a disaster is that certain health care resources may become limited or overwhelmed. In ordinary (non-disaster) circumstances, those who are sickest or most

severely injured generally receive treatment first followed by others in order of severity.[3] 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. In these situations, decisions will need to be made regarding the allocation of limited resources and not everyone will be given the level of care they would normally expect to receive. This includes those directly affected by the disaster as well as those not directly affected by the disaster but who otherwise require medical care.

4.2 Resources that may become limited include not only therapeutic goods such as medicines and medical devices but also resources such as medical equipment (eg. ventilators, diagnostic imaging machines), hospital beds, dressings and personal protective equipment; specialist critical care environments such as operating theatres; and personnel such as specialist medical staffing and support staffing (eg. administrative staff, orderlies). The allocation of resources should rest on principles of proportionality, equity, justice and clinical need, and patient's expressed wishes.

4.3 As in ordinary circumstances, access to health care including limited resources during a disaster should be based on an individual's medical status and predicted response to treatment, never on non-medical criteria such as race, religion, gender, age, nationality, social status, political affiliation or perceived 'social worth.'

4.4 Access to health care can be further compromised during a disaster for populations who are already marginalised, vulnerable or otherwise disadvantaged. Decisions to allocate limited resources should not result in further marginalisation of such individuals and groups.

5. The allocation of limited, potentially life-sustaining resources

5.1 In relation to the allocation of limited resources, the most challenging situations involve the allocation of potentially life-sustaining resources (eg., ventilators or blood products) and may involve decisions not to actively treat gravely ill or injured individuals who cannot be saved in the specific circumstances of time and place in order to treat others who can be saved.

5.2 Health care facilities should have specific protocols in place (prior to a disaster occurring) to support doctors and health care teams in making difficult resource allocation decisions in the event of a disaster. An example would be using existing Clinical Ethics Committee or setting one up as resources become overwhelmed. Protocols or ethical frameworks should be developed in consultation with, and supported by, the medical profession and wider community. Such consultation facilitates greater professional and community understanding, and acceptance of why certain decisions are made, including those where particular individuals are not offered potentially life-sustaining resources.[ii]

5.3 Such protocols should be fair, impartial, ethically and legally defensible and incorporate a system for procedural justice. They should align with jurisdictional health department requirements, be well-established, based on the best available clinical data and opinion, dynamic and responsive to changing circumstances including resource availability and promulgated within the health care facility and to the wider community.

5.4 In situations where it is necessary to allocate a limited, potentially life-sustaining resource, doctors will need to assess if an individual is likely to medically benefit from that resource. Doctors should consider an individual's medical status and predicted response to treatment, taking into account multiple factors such

[3] In ordinary circumstances, doctors have an important role as stewards of health care resources. Doctors should appropriately manage resources (through avoiding or eliminating wasteful expenditure) to ensure affordable care now and in the future. For further information, see AMA *Position Statement on the Doctor's Role in Stewardship of Health Care Resources 2016.*

as the clinical severity of the condition, any co-morbidities and the likely burden of the treatment on the person.

5.5 Where possible, the doctor should determine the patient's own wishes regarding potentially life-sustaining treatment. Where a patient does not have decision-making capacity, the doctor and the patient's substitute decision-maker should be guided by the patient's advance care plan.[iii] Individuals are strongly encouraged to develop advance care plans outlining their wishes and goals of care should they lose decision-making capacity in the future. If a patient does not have an advance care plan (or it is otherwise unavailable), the doctor and substitute decision-maker should be guided by the person's known wishes and goals of care. A patient's informed refusal of treatment, including potentially life-sustaining treatment, should be respected.

5.6 A decision not to provide a patient with a potentially life-sustaining treatment should be carefully and sensitively explained to the person and their family. Doctors are not obliged, however, to provide treatments that are considered to have no medical benefit.

5.7 Patients who are not allocated a potentially life-sustaining resource should never be abandoned and should be given appropriate care including palliative care and symptom management.

5.8 Disasters can impact the ability for patients and their family members to practice rituals, traditions or other religious or spiritual practices related to death and dying, further exacerbating their grief, bereavement and mental health distress. Family members and carers should receive appropriate support before and after their loved one has died.

6. Doctors and personal risk of harm

6.1 While there is a general expectation within the community that doctors will accept a certain amount of personal risk when responding to a disaster, doctors are entitled to protect themselves from both physical and mental harm and should not be expected to exceed the bounds of reasonable personal risk.

6.2 Minimising a doctor's personal risk of harm not only benefits the individual doctor but the wider community by ensuring the doctor is available to continue to care for patients in the future. Additionally, in some situations a doctor who places themselves at risk of harm may put others at risk as well. For example, a doctor who becomes infected with a pandemic-related virus may inadvertently pass the virus on to patients, colleagues, other health care workers or the wider community as well as the doctor's own family members.

6.3 Some doctors may be more exposed to risk than others when responding to disasters; for example, doctors working in emergency departments during a pandemic will likely have greater risk of disease exposure than those working in other specialties while junior doctors may have greater risk of disease exposure than more senior colleagues as they are more likely to serve different roles and work longer hours.

6.4 In order to practice safely and reduce their risk of personal harm, doctors should undertake a risk assessment of their own clinical situation including their personal health and medical susceptibilities and the safety of their work environment.

6.5 Doctors who are able to work are encouraged to do so as long as they are provided with a safe work environment. Employers have a responsibility to provide their staff with appropriate safety and protection including relevant training (eg, training in the use of personal protective equipment) in order to mitigate the risk of harm.

6.6 Doctors' risk of personal harm is a workplace Occupational Health & Safety issue and Federal and State workplace safety obligations should not be abandoned during disasters. Psychosocial safety is as important as physical safety and claims for psychiatric injury arising from disaster response should be recognised as workplace injuries and not be simply denied or obstructed.

7. Supporting the medical profession during and after a disaster

7.1 While doctors have an ethical and professional obligation to meet the increased demand on the health care workforce when responding to a disaster, employers, governments, other relevant third parties (eg, insurers) and the wider community have a reciprocal obligation to protect and support doctors (and their families) during and following on from the disaster.

7.2 Disasters place an extraordinary demand on doctors and other health care workers. Doctors may face greater personal and professional challenges when responding to a disaster including (but not limited to):

- greater professional duties;
- increased occupational risks;
- risk to professional liability;
- loss of income;
- discrimination and possibly stigmatisation;
- risk of personal injury, illness or death;
- isolation from colleagues, family and friends;
- increased physical, emotional and mental stress;
- potentially exposing family members and others to increased risk of illness, injury or death; and
- possible damage or destruction of professional premises or personal property (eg, loss of a doctor's family home or medical practice during a bushfire).

7.3 Doctors should be provided with appropriate support to meet their personal and professional obligations during disasters so they can continue to provide health care to those in need. Examples of appropriate support include (but are not limited to):

7.3.1 Addressing the increased demand on the health care workforce through:

- maintaining a safe work environment including providing sufficient and appropriate personal protective equipment. The safety of all health care workers and adherence to workplace health and safety laws must be an absolute priority for all governments in order to maintain healthcare delivery capacity during a disaster;
- recruiting retired or semi-retired doctors (and other healthcare workers), reassigning doctors out of their usual clinical fields and utilising medical students as physician extenders or clinical aides. Such workforce measures must be undertaken only with due consideration of clinical outcomes, personal and community safety outcomes and without coercion. Participation should be voluntary and those who choose not to participate should not be stigmatised or otherwise disadvantaged. Those who do participate should receive support including appropriate industrial protections, remuneration, training, supervision and medical indemnity;
- providing doctors with sufficient education, information, guidance, training, supervision (where appropriate) and support required to fulfil their duties;
- ensuring ongoing and appropriate medical indemnity protection for doctors including those who volunteer to work outside their scope of practice;
- providing for the ongoing educational and training needs of medical students and doctors-in-training whose study may be disrupted as a result of the disaster;

- facilitating timely access to care for patients with pressing clinical needs not related to the disaster (this should involve both the private and public health system to provide the usual care of patients and community access to care during and after a disaster);
- ensuring appropriate information communication and dissemination.

7.3.2 Managing any disaster-related disruption to medical education and professional development by:

- addressing the means to maintain the adequate education, assessment and continuous professional development of all doctors. This includes those in training and medical students as well as the impact of the disaster related workforce and training disruption on the continuing visa status of internationally trained doctors;
- providing education in disaster management and response during medical school, throughout training and through continuing professional development.

7.3.3 Ensuring the medical workforce is prepared to respond to different types of disasters such as pandemics as well as mass casualty events. This includes ensuring:

- everyone involved in the prevention, preparedness, response and recovery of disaster health undertakes education and training to ensure up-to-date knowledge and to maintain their skills at an appropriate level;
- that doctors-in-training and medical students are educated in disaster management to supplement capacity during a disaster;
- doctors who may be involved in the disaster response maintain their clinical skills at a level appropriate for their specialty.

7.3.4 Supporting doctors' physical and mental health needs during and after a disaster. The fear of illness or injury, combined with workforce shortages, long hours and fatigue, and a lack of access to leave can impact on the capacity of doctors to continue to provide adequate health care. Appropriate support includes (but is not limited to):

- 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 a disaster;
- protecting doctors' (and their families') privacy and confidentiality (eg. not publicly identifying doctors undergoing quarantine during a pandemic);
- ensuring the fair and appropriate designation of individual doctors' roles and responsibilities;
- ensuring the equitable distribution of risk among individual doctors responding to a disaster;
- ensuring provisions are made to have medical facilities up and running as quickly as possible, including facilities lost or damaged during the disaster, where possible, to meet health demands including having adequate resources and appropriate personal protective equipment;
- facilitating access to mental health care including debriefings and other psychological care where required;
- planning for follow-up personal support for all doctors to ensure ongoing psychological wellbeing after the crisis has passed;
- acknowledging the enormous stress that disaster response may cause doctors and workers in the health care sector.

7.3.5 Supporting doctors to meet their personal obligations (where appropriate) such as:

- providing flexible workplaces;
- facilitating childcare arrangements for doctors with young children;
- assisting doctors to protect the health and safety of their family members; for example, by providing appropriate accommodation options for doctors unable to return to their homes during a disaster or providing transport options to allow doctors to move safely between healthcare facilities;

- helping doctors who have lost their clinics during a disaster to get the facilities up and running as soon as possible, particularly in rural and regional areas.

8. Supporting each other

8.1 Doctors have an ethical and professional obligation to look after their own health and well-being as well as the health and well-being of colleagues who may be experiencing disaster-related physical and/or mental health issues. This includes those experiencing direct physical injury or illness as well as those experiencing physical and mental health issues including exhaustion, burnout, increased stress and anxiety, moral distress, depression, grief, financial stress and bereavement.

8.2 Doctors should recognise that stress and anxiety are normal reactions when responding to disasters; however, it is important to be aware that individual doctors may respond differently to the same stressor and recognise the potential for stress disorders to develop in colleagues. This may not be apparent for some time or may only become apparent when a similar disaster occurs.

8.3 It is important to ensure that colleagues are provided with appropriate mental health support so they can discuss their concerns without fear of judgement or stigmatisation. This can include having safe spaces to debrief as well as more formal consultations including via telehealth.

8.4 Doctors and health care institutions should also be mindful of the power structures that exist in the health care workforce, particularly in relation to the power imbalance between junior and senior staff. This power imbalance can negatively impact on the ability of junior staff to raise issues of concern in relation to their own mental and physical health, the expectations on their workload or scope of practice, the health or conduct of colleagues or the safety of the environment.

8.5 Doctors should work collaboratively with other health care professionals in the care of patients and the wider community and promote solidarity within the health care community.

8.6 Doctors should alert appropriate authorities (including the union) when the health care service or environment within which they work is inadequate or poses a threat to health;[ii] for example, where there is inadequate provision of personal protective equipment. Doctors who legitimately raise such concerns should be responded to appropriately, supported and protected and should not be punished or discriminated against for their actions. This also includes when a doctor makes a complaint against a colleague or other health care practitioner.

9. Clinical research during, and directly related to, a disaster

9.1 Clinical research is key to evaluating the safety and efficacy of therapeutic interventions that may be required during a disaster. There may be circumstances during a disaster where urgent clinical research into therapeutic interventions directly related to the emergency is required and resources may need to be directed to focusing on such research. For example, clinical research into treatments and vaccines for a pandemic disease for which there is no known treatment.

9.2 Conducting clinical research directly related to the disaster, however, can be particularly challenging as it may be undertaken in an environment where there is pressure to act quickly and there may be competing and confusing lines of accountability, uncertainty and distress. This can add to the risks that research, however well intentioned, could cause direct harms or inadvertently add to existing injustice and exploitation.

9.3 While time critical, the pressure to undertake urgent research during a disaster does not justify relaxing the standards for ethically conducted research such as those set by the National Health and Medical Research Council.

9.4 In such situations, substandard research can not only result in direct harm to patients and others but can also undermine public confidence in the safety and/or efficacy of the treatment itself, medical care more broadly as well as the medical profession, governments and the wider health care industry (such as the pharmaceutical and medical device companies).

9.5 Where clinical research is urgently required to respond to the disaster, it is important to be able to disseminate and publicise research findings (both locally and globally) including negative findings for the benefit of patients and the wider community as soon as it is quality-controlled for release.

9.6 Such research should be conducted only if it does not impede emergency response efforts or take away from routine health care and public health services.

9.7 Following on from a disaster, it is important that clinical research is conducted on:

- the safety and efficacy of the therapeutic and public health interventions undertaken during the disaster;
- the short and long-term health impacts of the disaster itself including the direct impacts (such as disaster-related injuries or sickness) and the indirect impacts (such as delayed cancer screenings); and
- the direct and indirect short and long-term health impacts of the disaster response itself (for example, the mental health impacts of isolation during an extended pandemic lockdown).

9.8 Where ongoing research not related to the disaster is consequently disrupted, this should be undertaken in an orderly manner that mitigates any adverse impact on the ongoing research and ensures that any research already conducted is not lost.

9.9 As appropriate, facilities should undertake relevant quality assurance activities to learn from their own individual responses and identify issues of concern and areas for improvement at their own local level.

10. Doctors' roles as government medical advisers

10.1 Doctors have different roles and responsibilities in disaster response with many working in clinical, research, administrative or combinations of these roles. Some doctors, however, will work in government medical advisory roles where they will have significant influence on government policies affecting public health during a disaster and, for those also acting as government health spokespersons, will have particularly important roles in publicly advocating the government's public health messaging.

10.2 While recognising that doctors serving as government medical advisers have a professional obligation to support and promote government policies in relation to disaster response, they also have an ethical and professional obligation as medical practitioners to uphold the values and principles of the medical profession[4] and advocate that the principal driver of government policy remains the health and wellbeing of the community. They should be empowered to voice their concern if a particular policy might be detrimental to the public's health.

[4] Refer to the AMA *Code of Ethics 2016* and the AMA *Position Statement on Medical Professionalism 2015* for information on the ethical values and principles that guide the medical profession.

10.3 It can be difficult for these doctors to balance their obligations to both the government and to the community as a medical professional and they may experience dilemmas when the government's political view and the broader public health perspective on a particular aspect of disaster response are not aligned.

10.4 In these roles, doctors should:

- have the freedom to provide governments with independent, objective and scientifically valid medical and health advice that prioritises the health and well-being of the community;
- be able to raise issues of concern in relation to decisions that are based on the misuse or selective use of information, or that do not align with the public health perspective, without fear of repercussion or persecution;
- be able to speak with integrity to the public when serving as government health spokespersons.

10.5 Mutual trust and respect is vital to ensuring effective public engagement with public health measures. In order to facilitate this, governments must:

- regularly engage with the broader community;
- keep the public informed about the disaster response with simple, clear, consistent and accurate messaging;
- ensure the process and rationale for public health measures are accountable and transparent;
- ensure the data used to make public health decisions is made publicly available and accessible in a timely manner.

10.6 Politicising the public health response to a disaster can be socially harmful and undermine the community's willingness to accept and adhere to public health measures imposed by governments. The public health response to a disaster should be informed by available evidence and based on health and well-being criteria and not manipulated to achieve political or commercial ends.

11. The role of the AMA as a public advocate during a disaster

11.1 The AMA is an independent organisation considered one of the most ethical and trustworthy associations in Australia.[5] The AMA serves an important role in public advocacy during disasters through:

- identifying and mobilising trusted local health experts who can provide objective and reliable health information;
- disseminating objective, reliable and trustworthy health information to the public;
- guiding and leading public discussion on health issues;
- providing public reassurance and support without being constrained by bureaucracy or political pressures;
- providing objective, reliable and trustworthy health advice to governments;
- drawing critical attention to misleading or inaccurate health information;
- calling out those who may take advantage of a disaster for their own personal gain;
- tempering sensational media coverage and encouraging fair, objective media reporting of health issues;
- advocating that health care remain at the forefront of the government's response to a disaster;
- advocating that the health care response is fair and equitable throughout Australia;
- promulgating Australia's ethical responsibility to look after our regional neighbours and the wider global community, particularly less developed countries who may also be affected by a disaster.

[5] The AMA is consistently voted the first or second most ethical/trusted organisation in the member association sector in Australia by the Governance Institute of Australia.

11.2 The AMA will work with governments to assist doctors and the health system to be able to do their jobs during a disaster. This includes looking at alternative ways to work such as telehealth and to work with the government and the health system to provide clear and reliable communication of the science as well as reinforcing government messaging.

References

Australian and New Zealand Intensive Care Society (2020) *ANZICS COVID-19 Guidelines.* Melbourne: ANZICS.

Australian and New Zealand Intensive Care Society. *Guiding Principles for Complex Decision-Making During Pandemic COVID-19.* Melbourne: ANZICS.

Australasian College of Emergency Medicine. Clinical Guidelines for the Management of COVID-19 in Australasian Emergency Departments. Vol. 1. 26 March 2020.

Australian Disaster Resilience Handbook 1: Disaster Health, 2011, Australian Institute for Disaster Resilience CC BY-NC.

Palliative Care Australia. *Palliative Care During the COVID-19 Pandemic.* 2020.

Relevant AMA and related policies

AMA Code of Ethics 2016
AMA Federal Council COVID-19 Communique 2020
AMA Position Statement on End-of-Life Care and Advance Care Planning 2014
AMA Position Statement on Involvement of GPs in Disaster and Emergency Planning 2016
AMA Position Statement on Medical Professionalism 2015
AMA Position Statement on Supporting GPs in the Immediate Aftermath of a Natural Disaster 2021
AMA Statement on Vaccination for COVID-19 2020
WMA Statement on Medical Ethics in the Event of Disasters. Adopted by the 46 WMA General Assembly, Stockholm, Sweden, September 1994 and revised by the 57 WMA General Assembly, Pilanesberg, South Africa, October 2006 and revised by the 68 WMA General Assembly, Chicago, United States, October 2017

[i] *WMA Statement on Medical Ethics in the Event of Disasters*. Adopted by the 46 WMA General Assembly, Stockholm, Sweden, September 1994 and revised by the 57 WMA General Assembly, Pilanesberg, South Africa, October 2006 and revised by the 68 WMA General Assembly, Chicago, United States, October 2017
[ii] Palliative Care Australia. *Palliative Care During the COVID-19 Pandemic*. 2020
[iii] *AMA Position Statement on End-of-Life Care and Advance Care Planning 2014*