Ethics and Epidemics

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A HISTORICAL LOOK AT THE DUTY TO TREAT

In 166 AD, an epidemic of smallpox struck Rome, Italy. The Greek physician Galen, who had already acquired a reputation for his dissections, fled the city (Nutton 2002). The abandonment of patients during epidemics was not necessarily frowned on by fellow physicians, or, for that matter, the population at large. During the Middle Ages, however, chroniclers started to criticize physicians for abandoning patients during severe and widespread epidemics. When the plague reached Venice, for example, physicians fled in flocks to avoid contagion. In 1382, the problem had reached such proportions that the city passed a law forbidding physicians to flee in times of plague, and other major European cities followed suit shortly thereafter (Zuger and Miles 1987). The very existence of these laws indicates the extent of the practice.

Similar examples of physicians fleeing afflicted cities or hospitals are easily found, right up to modern times. In 1976, an outbreak of Ebola hemorrhagic fever erupted in Yambuku, a small town in the Democratic Republic of the Congo (DRC). Eleven of the 17 hospital staff died from the disease. When Ebola hit Kikwit General Hospital (DRC) in 1995, hospital personnel were not so devoted. Tom Ksiazek, of the Special Pathogens Branch of the Centers for Disease Control and Prevention (Atlanta, GA), arrived at the hospital to find 30 expiring patients, some sharing beds with the deceased (1999). All the physicians and nurses had fled. The bottom line, it seems, is that history provides little guidance on what constitutes the 'duty to treat'. Daniel Fox (1988) writes:

> Much of the evidence about physicians abandoning patients during epidemics, when read in context, furnishes no proof that such conduct violated prevailing ethical norms (6).

With air travel, population movements, drug resistance, global warming and a host of other factors, pathogens can spread around the globe with unprecedented ease. The increasing threat of exotic and virulent epidemics signals a pressing need to examine the nature and limits of clinicians' duty to treat. Malm and colleagues' (2008) target article is a welcome addition to the growing literature on this thorny issue.

THE RISKS AND LIMITATIONS OF THE 'DUTY TO TREAT'

My own interest in the subject arose in summer 2003, during a bioethics internship in a large Toronto (Ontario, Canada) hospital. Although I arrived a week after the severe acute respiratory syndrome (SARS) epidemics were officially declared over, the specter of SARS very much remained. Masked healthcare workers (HCWs) squirted alcohol gel on my hands and took my temperature on each visit to the hospital. "How are you feeling today?" they would ask each time. Two healthcare workers died of the disease during my 1-month stay. In the corridors of the hospital, conspicuous posters praised the work of HCWs, calling them 'heroes'. In private conversations, there was also much talk of the HCWs who refused to work during the epidemics. Some of the clinicians and bioethicists who frowned on the deserters invoked 'duty of care', using the phrase as a trump card to justify what they considered to be unethical behavior.

Used in this loose, authoritative manner, I felt the phrase *duty of care* (or *duty to treat*) could be ethically dangerous. It could pressure HCWs into working in unacceptably risky conditions while presenting the "illusion of legitimate moral justification" (Sokol 2006, 1238). To counter this threat, I tried to develop an account of the duty to treat that would allow us to establish with confidence when it does and does not apply. Despite my best efforts, I did not succeed. I suggested nonetheless that the limits of the duty were contingent on various factors, many of them mentioned by Malm and her colleagues (2008), including the "normal risk" (4) level (hence, a physician working in rural DRC with poor facilities can expect to incur higher risks than a physician in an English village), the clinician's specialty (compare the ophthalmologist with the infectious disease specialist), the likely benefits of treatment to the patient and the risks to the clinician. I also argued that the duty is not absolute but *prima facie* (or, to be more precise, *pro tanto*) (Sokol 2006). In other words, the duty should be discharged unless it conflicts with one or more other duties with greater moral force.

MULTIPLE AGENCY

A clinician's duties are not limited to clinical duties. Clinicians are multiple agents, belonging to the medical profession but also to other moral communities. A physician may also be a husband, a parent, a brother, and a son, and each of these roles carries its own obligations. In virulent epidemics of infectious disease, especially when the risks to oneself are high and transmission to loved ones a distinct possibility, the *prima facie* obligation to care for the sick may conflict with other non-clinical moral obligations.

Malm and colleagues (2008) are quite right to distinguish between obligatory and supererogatory acts. Shortly before her death, a retired nurse in Toronto called the hospital ethicist to her bedside to recount a moral dilemma she

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experienced in 1942, in Penang, Malaysia (Sokol and Bowman 2005). The Japanese Imperial Army was swiftly approaching the military hospital in which she was working as a nurse. All HCWs and patients were ordered to evacuate the hospital. There were 126 soldiers who were unable to walk the 11 miles needed to reach the British ships heading for Singapore. These non-ambulatory patients would likely be killed by the Japanese army. The nurse, 50 years later on her deathbed, was still struggling with the apparent moral dilemma: Was she right to flee, abandoning her patients, or should she have cared for them until the bitter end? Although two HCWs stayed behind with their patients, any theory that judges that such an action is obligatory, rather than beyond the call of duty, is so unrealistically demanding as to be flawed. The duty to treat has to be tempered with HCWs' rights to self-preservation.

CONCLUSION

One cannot consider HCW's duty to treat without acknowledging that HCWs are multiple agents, wearing various hats, and consequently bound by potentially conflicting moral duties. The moral strength of a particular HCW's duty to treat cannot be established in a vacuum, but must take into account the contextual features of the decision. I doubt we can reduce these innumerable contexts into general norms. "It is the mark of an educated man," Aristotle wrote in his *Nicomachean Ethics*, "to look for precision in each class of things just so far as the nature of the subject admits" (1954, 3).

Although as an academic I want to elucidate the duty to treat as far as the subject admits, as a citizen I am far more concerned with avoiding staffing chaos when disaster strikes. I wholeheartedly agree with Malm and colleagues (2008) that we should not ignore the practical, staffing aspects of pandemic planning. The lessons of history are clear: In the absence of specific guidelines or instructions, some HCWs will flee from virulent epidemics. Any open debate about the scope of clinicians' 'duty to treat' and its practical implications will be uncomfortable, but the costs of avoiding it are too great. ■

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A Duty to Treat During a Pandemic? The Time for Talk is Now

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Future pandemics, and in particular, an influenza pandemic, will create demands on our healthcare systems that will not have been faced by healthcare professionals (HCPs) in recent decades. The demands will far exceed the resources available, including human resources. It will be necessary to attempt to meet those demands, at least if we as a

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