DUTY TO CARE: ACKNOWLEDGING COMPLEXITY AND UNCERTAINTY

As a regulated health professional what are your obligations in situations such as SARS, a Katrina-like event or an influenza pandemic? Do you know? If you do not know, where would you seek guidance? Have you had a conversation about these issues with colleagues? With your family? With management? With your professional association?

The issue of duty to care is one of profound ethical significance. In communicable disease outbreaks, individuals providing care may expose themselves or their family to the risk of infection, which could lead to serious morbidity and possibly death. Most healthcare workers are in ethically complex situations, balancing other-regarding obligations (to colleagues, patients, family, for example) and self-regarding obligations (to maintain wellness). Members of the public may expect healthcare workers to behave in a self-sacrificing way, serving society like members of the armed forces or emergency forces with no chance to opt out of situations of significant personal risk.

The ability of healthcare professionals to be adversely affected in the context of their duties is not new. History records the enormous danger and high mortality of physicians and nurses during the great epidemics of the first two centuries following the death of Christ. And there is ample evidence in medieval stories of the Black Death of the great catastrophe for carer and cared for alike. In more modern times, the epidemics of cholera, yellow fever and other infectious diseases took a high toll in the nineteenth century on adults and children and all who attended them. During those terrible times, not everyone stayed at their post risking their lives for the common good, but those who did were certainly much lauded as public heroes and heroines.

Perhaps it should come as no surprise then that in recent surveys a significant proportion of healthcare providers express an unwillingness to work if a pandemic should occur. This response has profound implications for the health professions. How then should we think about these issues?

Learning from SARS

The SARS pandemic and outbreak in the Toronto area stimulated an interdisciplinary and interprofessional research program into the issues raised in the care of individuals with communicable diseases. These issues are founded primarily in ethical concerns. Infectious diseases have been neglected to some extent by bioethics scholars, in part because they have concentrated on the application of healthcare technology and the new genetics. As infectious disease moved out of focus for scientists and health policy experts during the late twentieth century, the health professions too seemed lulled by a false sense of security that epidemics were a thing of the past, and that personal risk was no longer part of the daily reality of health work.

Post-SARS and a decade characterized by rising global concern over avian influenza, it is clear that communicable diseases are once more very much on the agenda. But the contemporary context of health-care and professional life means a new set of profound challenges have come into existence for the care of those whose illness puts others at risk. For instance, infectious diseases strain traditional and familiar concepts such as autonomy. An outbreak in a complex healthcare system highlights the need for reflection across the boundary from personal to global ethics. Although pandemics and novel viruses like SARS highlight universal vulnerability, this vulnerability generates equally novel social and ethical challenges due to contemporary professional values which emphasise autonomy and individuality as well as duty to care.

A paper in the British Medical Journal in 2003 highlighted issues with respect to duty to care and concluded that there was a fear for personal safety that needed to be balanced with professional obligations (Singer et al. 2003). However, research conducted in Toronto has found that many healthcare providers were ill-prepared to face such demands. They were unaware that in their work they could risk illness to themselves and spreading it to family members. In fact, in the aftermath of SARS, many were considering alternative careers (Bensimon et al. 2007).

Furthermore, a survey of a large healthcare institution involved in the SARS outbreak showed that the psychological impact of the episode was substantial: 45% of nurses scored above the General Health Care Questionnaire cut-off point for psychological stress and 65% of all respondents indicated a concern for personal health (Nickell et al. 2004).

Recent research indicates that codes of ethics and regulatory authorities provide insufficient guidance to health professionals. A review of codes of ethics indicated that, for the most part, directive guidance was not given (Ruderman et al. 2006). Traditional ethical notions such as autonomy, beneficence, and non-malefeasance will only carry so far because they do not indicate how one weighs the competing obligations between self and others. Contracts are limited by
the fact that workers have a right to a safe workplace. Most contracts do not address duties and responsibilities during situations such as a pandemic. There does not appear to be a single unified view that would resolve the necessary trade-offs entailed by duty to care considerations. Indeed, respondents in a post-SARS Toronto study started out with strong statements regarding healthcare professionals’ unbounded duty to care. However, they quickly retreated from this stance in light of considerations such as parental obligations or increased vulnerability related to personal health status (Bensimon et al. 2007).

What such reactions/responses indicate is that there is no single accepted view of duty to care, and health systems must acknowledge this. As collections of professionals and as societies, we need to recognize the complexity of competing obligations and look frankly at the durability and applicability of traditional notions such as duty to care. Research indicates that relegating such decisions to personal choice is an inadequate and morally questionable strategy. Decisions are not made in isolation from personal, familial, community, institutional, and societal context and duties cannot be fulfilled without support within this broader context (JCBI Working Group 2008). The empirical findings do remind us that consideration of the social context, the perceptions and beliefs of healthcare workers and members of the public cannot be ignored in pandemic planning.

The report Stand on guard for thee conceptualized the issue as a problem for human resources strategy, and noted the importance of including all stakeholders in dialogue to clarify roles and expectations (Upshur et al. 2005). The outcome of this report challenges the utility of punitive sanctions and posits duty in terms of engagement as opposed to self-sacrifice.

**Engagement**

Whatever approach is taken one thing is for sure, traditional values such as duty to care are strained under contemporary workforce, policy and regulatory contexts. What is needed locally and globally is a commitment to civic engagement on this critical issue. A discussion needs to occur between healthcare professions, non-healthcare professions, policymakers, regulators, and the general public. By drawing on the principles of solidarity, reciprocity, and wise stewardship, we may be able to craft a human resource strategy that allows us to face difficult challenges without producing undue hardship on those who may have difficulty in determining priorities due to conflicting obligations.

**References**


Upshur REG, K Faith, JL Gibson, AK Thompson, CS Tracy, K Wilson and PA Singer. 2005. Stand on guard for thee: Ethical considerations in preparedness planning for pandemic influenza. A report of the University of Toronto Joint Centre for Bioethics Pandemic Influenza Working Group.

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