

# Medicine's Duty to Treat **PANDEMIC ILLNESS**

## SOLIDARITY AND VULNERABILITY

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Most accounts of why physicians have a duty to treat patients during a pandemic look to the special ethical standards of the medical profession. An adequate account must be deeper and broader: it must set the professional duty alongside other individual commitments and broader social values.

In the wake of SARS and with the possibility of bioterror, pandemic avian influenza, and other emerging infections looming, bioethicists are exploring the extent of a health professional's duty to treat the victims of such an infectious outbreak, even at some substantial risk to the caregiver's own health or life. The World Health Organization announced in August 2003 that 20 percent of all persons known to have been infected with SARS were health care workers. Three of the forty-one people who died of SARS in Canada were health professionals, as were six of the 180 who died in Taiwan.<sup>1</sup> Dr. Carlo Urbani of Médecins Sans Frontières, who with others initially identified SARS as a new infectious disease in Hanoi, voluntarily quarantined himself and eventually died of SARS, leaving a widow and three chil-

dren.<sup>2</sup> Should we regard Dr. Urbani as a medical hero, or as a physician simply doing his duty?

Physicians' moral duties arise from at least two sources. As members of society, they owe the same general duties to others as any citizen. In addition—as one of us has previously argued—they assume a further set of moral duties connected with the nature of medicine as a practice. By announcing to the community that they are practitioners of medicine, physicians implicitly accept and undertake these duties.<sup>3</sup> Although the core features of the internal morality of medicine persist over time, the interpretations of these duties are not static and are implicitly renegotiated with society as the practice of medicine evolves.<sup>4</sup>

The internal morality of medicine consists of both goals and ethical side constraints. The goals of medicine, which physicians ought to promote, include healing and curing but also extend to prevention, rehabilitation, palliation, reassurance, and health education. The side constraints distinguish

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the appropriate from the inappropriate ways of pursuing those goals. Physicians should be technically competent and truthful about the nature of their craft, avoid causing harm that is disproportionate to anticipated benefits, and serve as loyal patient advocates.<sup>5</sup>

Our account of the internal morality of medicine provides a *prima facie* answer to whether physicians have a duty to treat pandemic illness. All members of society have an ethical duty to rescue others in dire need of help when they are in a position to do so. Physicians arguably have a role-specific duty of rescue by virtue of their medical competence to provide the help that victims of infectious outbreaks require. The goals of medicine include curing when possible and minimizing patients' suffering when curing is not possible. Physicians are duty-bound as fiduciaries to the interests of their patients. It therefore appears that physicians cannot, with integrity, refuse to serve the victims of an infectious outbreak out of fear of contracting the disease. This duty to treat is strengthened by organizational structures related to professional status that assign to physicians exclusive control over many resources and skills needed to assist patients, such as the right to prescribe medication. Having effectively denied non-physicians the means to assist victims of pandemics, physicians appear even more duty-bound to help.

This *prima facie* account, however attractive initially, turns out on further exploration to be insufficient to sustain a robust duty to treat. Recent work that attempts to apply lessons from the SARS outbreak to a possible avian influenza pandemic provides some illumination. The discussion must be broadened from physicians to include not only all health professionals, but also the nonprofessional service workers without whom any hospital would soon cease to function.<sup>6</sup> The health care worker's other obligations, especially for the care of family members, must be considered alongside duties owed to patients. Fi-



SARS Ward, by Eric Avery.

2007, woodcut, 26" x 34". Courtesy of the artist, [www.docart.com](http://www.docart.com).

nally, a deeper account of the professional's duty to treat will eventually have to address in detail important concerns of *social solidarity*. Three levels must be addressed: Solidarity among health workers within institutions, solidarity between health professionals and the community, and the commitment of the community as a whole to its most vulnerable members.

### Justifying a Duty to Treat

Despite the strong *prima facie* case for a robust duty to treat, providing an ethical justification for this duty has proved more daunting than many anticipated. Lawrence McCullough, for instance, offers one of the few systematic treatments of physicians' legitimate self-interests that counterbalance their professional responsibilities. He includes among these interests sufficient time to engage in hobbies and other leisure activities.<sup>7</sup> If hobbies constitute an ethically acceptable self-interest, preserving one's own life would seem to be a more compelling one. But recognizing that interest would pull the rug out from under any meaningful duty

to treat in the face of substantial risks to life and health.

Many assume that the historical traditions of medicine provide at least a partial justification for a strong duty to treat. Careful analysis of the historical record, however, reveals a decidedly mixed picture.<sup>8</sup> Between the early nineteenth and the mid-twentieth centuries in the United States, a duty to treat even at considerable personal risk was widely accepted by physicians. Before that, from late medieval times into the eighteenth century, physicians commonly fled the city when an epidemic struck.

If the historical record is univocal on any point, it would seem to be that the duties that physicians accepted were contingent upon the physicians' place and role in society, and on a negotiation between the medical profession and the community at large. Usually this negotiation was implicit, but occasionally it was conducted explicitly. For example, when plagues afflicted Europe between the fourteenth and seventeenth centuries, the civic authorities often compensated for the flight of the town's regular physicians by paying enough to at-

tract a cadre of "plague doctors" to replace them.<sup>9</sup>

The AIDS crisis of the 1980s surprised those who had assumed that the duty to treat still held. They did not anticipate the effect of the soothing myth, promulgated during the 1960s, that epidemics had been conquered and so risking death while treating patients was no longer a part of the physician's job description. Told that there was a small chance of contracting a disease thought then to be 100 percent fatal from treating an HIV-positive patient, at least some younger physicians said in effect, "Wait a minute—I never signed up for this." This disconnect between traditionally accepted ethical obligations and actual physician behavior led to a flurry of ethical analysis. Data showing that the risk of patient-to-physician transmission was very low quickly provided justification to those arguing for a strong duty to treat.<sup>10</sup> But because of this, when a disease like SARS struck, carrying a much higher risk of falling ill and dying from patient contact, the ethical dialogue around HIV/AIDS turned out largely to be beside the point.

The advent of SARS revealed another serious limitation to the ethical tradition of a strong duty to treat. When American physicians endorsed this duty as it was expressed in early versions of the American Medical Association Code of Medical Ethics, they took a number of things for granted. For instance, they assumed physicians would be male. If they had families, then they also had wives, who were presumed to be primarily responsible for the care of hearth and home while the men attended to professional duties and business interests. If an epidemic struck the town, men could remain at their posts while their wives took the children to a place of safety.<sup>11</sup> Physicians who share equal duties for the care of dependents and possible travel restrictions that might keep an entire family at home or within the confines of the city were not contemplated as part of the ethi-

cal "contract" between physicians and society.

The SARS epidemic also highlights the ethical importance of the notion of *emerging* infectious diseases. In the case of a future pandemic, some health professionals (like Dr. Urbani in Hanoi) will become involved at the earliest stages simply because they are on duty; they will care for the first patients unaware that a pandemic has even begun. Others will be expected to commit themselves to serve at an early stage of the outbreak and to follow through on that commitment, especially if an entire hospital is quarantined and staff are prohibited from leaving. At the time a commitment to treat is made, either by circumstance or by choice, the data on the disease's actual rates of transmission and mortality will not yet be known.<sup>12</sup> These circumstances suggest how slippery it is to try to base a duty to treat on the precise extent of the risks, even if in principle the degree of risk seems highly relevant to the extent of the ethical duty.

#### Duty to Treat: Current Status

Neither our initial *prima facie* statement of physician obligation nor the account of the historical ethical tradition has proven sufficient to ground a robust duty to treat in the face of significant risks. In the face of this relative ethical disarray, a number of analyses have now appeared that examine the health professional's duty in the face of an infectious disease posing risks comparable to SARS or to the threatened pandemic of avian influenza.<sup>13</sup> To focus our discussion we will look particularly at two works derived from the SARS experience in Canada.<sup>14</sup>

The Pandemic Influenza Working Group of the Joint Centre for Bioethics at the University of Toronto addressed a health worker's duty to treat by appealing to substantive and procedural values. Of ten substantive values that generally should inform a community's response to the threat of pandemic influenza, it selected four

as specifically informing the duty-to-treat issue. The four values it identified were the duty to provide care; reciprocity, or society's duty to support those who assume disproportionate burdens to protect the public good; trust, both between patients and providers and between the community and public health authorities; and solidarity among health professionals, within the community, and among nations when fighting a pandemic. It defined this last value specifically as "collaborative approaches that set aside traditional values of self-interest or territoriality among health care professionals, services, or institutions."<sup>15</sup>

The remaining six substantive values that the working group identified were individual liberty, protection of the public from harm, proportionality, privacy, equity, and stewardship. It stated that though these values may be very helpful when applied to other ethical issues such as quarantine and allocating scarce resources, they are not directly pertinent to a duty to treat.

In contrast, the group found the procedural values it identified to be equally applicable to all ethical issues that arise in a pandemic, including the duty to treat. These values specify that a community's pandemic policy should reflect procedures that are reasonable, open and transparent, inclusive, responsible, and accountable. The group further recommended that professional organizations should instruct their members regarding their duty to treat in pandemic via codes of ethics. Government and the health sector, in turn, should guarantee that all means are used to protect health workers' safety, that risks are spread among workers equitably, and that provision is made for workers and their families, including disability and death benefits.

At first glance, the working group's approach appears consistent with the model of physicians' moral duties with which we began. Relying on codes of ethics promulgated by professional organizations suggests that

discernment of duties is in some sense *internal* to the various health professions. The values of reciprocity, trust, and solidarity recognize that this internal discernment is nevertheless in tension with a process of negotiation between health professionals and the larger community. The list of procedural values suggests that, ideally, this negotiation would occur explicitly instead, assuring its openness, transparency, and accountability. The group argues that this, in turn, would engender enhanced trust, which it highlights as one of the substantive values directly informing a duty to treat.

Nevertheless, one might object to several features of the working group's account. Readers—especially those in

relevant only to members of the public, and not to health workers themselves. Why did it not include these two values on the list of values relevant to the duty to treat?

The working group similarly appears ambivalent in invoking solidarity and the procedural values. The existence of a duty to treat and whatever limits of qualifications might apply to it do not appear to be a matter for negotiation; professional societies will simply instruct practitioners that this duty exists and must be adhered to. While it might well be true that the general public expects health professionals to adhere to such a duty, is there nothing to be said about its expected limits? We assume, for instance, that in the case of firefighters,

ers who must cooperate if care is to be effective? How can we assure that kitchen staff, housekeepers, and others who are unlikely to be members of a professional organization feel a similar duty to stay at their posts, since the work of the hospital would quickly grind to a halt without them? A professional balkanization of an ethical duty to treat does not appear to be a promising start.

The Toronto working group's analysis takes us only part way toward an adequate defense of a duty to treat on the part of all essential health workers. The group has identified the key moral values at stake. Yet the application and implications of all the relevant values remain only partially developed.

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the United States—will note that the group's overall list of substantive values includes "individual liberty" and "proportionality." Individual liberty is invoked to assure that in a public health emergency, coercive measures such as quarantine are used only when absolutely necessary.<sup>16</sup> Proportionality dictates that individual liberty is compromised only to the extent necessary to address the true threat. It would seem implicit in this analysis that when risk is high and public health measures cannot adequately protect the individual from it, the individual then has a right to remove herself from the risk situation, provided that she can do so without directly causing excess risks to others around her. If this reading is correct, then health providers might well wonder why the working group has seen individual liberty and proportionality as

community representatives can agree on a level of immediate risk to life that would countermand the duty to reenter a burning building to try to rescue those trapped inside.<sup>17</sup> If the success of the rescue is highly unlikely, the risk cannot be justified—there is, after all, no advantage simply to having more dead firefighters. But the model presented by the working group envisions no such negotiation between health professionals and the public that they serve.

The suggested model, moreover, appears potentially destructive to one key level of solidarity—the solidarity that exists among health workers within a facility such as a hospital. If each separate professional group must individually instruct its members on the duty to treat, how can we assure that these duties are articulated in complementary ways for all the work-

#### **Solidarity within Institutions**

Lynette Reid proposes that Canadian health workers faced with the risk of SARS generally provided exemplary patient care, in many cases rising to a level we would term heroic. They did so *not* by carefully calculating that the risk of SARS fell within some prespecified boundary where the duty to treat took precedence over self-preservation. Instead, Reid attributes the workers' behavior primarily to a sense of solidarity within the institution—what one might paraphrase as "we are all in this together." Any worker who contemplated avoiding duty in the name of personal safety could look over and see the fellow professional whose workload would be doubled as a result. When one of these workers then fell sick, her fellows took pride in being the first to offer care to her.<sup>18</sup>

Despite the aptness of the term in this situation, Reid is concerned about the label "hero" because she thinks that it is bad policy to rely on heroism to get us through foreseeable crises. She writes:

We must not expect individual moral heroism to do work that is best spread around: the obligation is on all of us to create and sustain

a healthcare system that does not leave the provision of our care dependent upon extreme actions of self-sacrifice by a limited group. Epidemics do create occasions for moral heroism—but it is incumbent upon us as a society not to multiply unnecessarily the conflicts between self-interest and altruism or beneficence that our healthcare system presents individuals with, in order to enjoy the sight of a great deal of moral heroism.<sup>19</sup>

To this end, it is worth noting that organizations, as well as individuals, can be virtuous. A virtuous organization encourages and nurtures the virtuous behavior of the individuals within it. At the very least, the virtuous organization avoids creating unnecessary barriers to the virtuous behavior of individuals. Generally, an individual is morally accountable for her own level of virtue. If she is forced to work within a peculiarly vicious organization, however, we may withhold much of the blame that we would otherwise attach to her failure to act virtuously.

Reid argues that within optimally virtuous health care systems, we will see many more professionals and other staff freely assuming a duty to care, thus assuring that we do not exploit a small cadre of heroes.<sup>20</sup> The working group continues this line of thought, stating that both government and health systems have a role to play in promoting this level of virtue. When institutions and the surrounding community step forward to assure workers that their own needs and the needs of their families will be looked after, workers will presumably be much more likely to provide care.<sup>21</sup>

Consider the example of a nurse who is caring for an elderly parent in her home.<sup>22</sup> Told to come to work in the face of a pandemic that could result in her being quarantined within the hospital for an indefinite period of time, and where her life would be put at risk, is she a bad person if she weighs her professional obligations

against her duties to care for those who depend upon her at home? According to McCullough's analysis, a health provider who could simply abandon her mother at home in the name of adhering to an abstract professional duty might not be the sort of human being we would wish to care for us, at least in normal times.<sup>23</sup> If, on the other hand, the hospital and the surrounding community had put a good deal of effort into organizing an assistance program that would provide care for the mother in such a situation, there is a much greater likelihood that the nurse would show up for work.<sup>24</sup> Within a virtuous institutional and community setting, she would not need to swim against a stiff current in order to act virtuously herself.

In one touching anecdote related by Dianne Godkin and Hazel Markwell in their 2003 report, *The Duty to Care of Healthcare Professionals*, a hospital staff member who faced the dual challenges of caring for SARS patients and being unable to leave the facility due to quarantine reported that the most meaningful event of her day was a phone call from a member of the Department of Family Medicine who simply asked how she was and if she needed anything.<sup>25</sup> This anecdote suggests how relatively simple the actions required to sow a sense of solidarity may be that can move people toward exemplary care of the sick in the face of personal risk and considerable inconvenience.

### **Solidarity between Profession and Community**

Sociologists of the professions have long employed a conceptual model by which “society” and “the profession” enter into an implicit negotiation. Society grants the profession powers and privileges—notably monopoly control over its practice and considerable freedom from outside regulation. Laypeople look up to members of the profession. In exchange, the profession agrees to accept some degree of sacrifice—it

places the interest of its patients and the general public above its own. A crude expression of this concept as pertains to physicians could be put this way: You run the risk of dying in the event of an infectious outbreak; we will admire you for it, and incidentally allow you to achieve an income level considerably above the average.

Samuel Huber and Matthew Wynia adopt this basic sociologic model and employ a value of reciprocity similar to the Toronto working group's when they suggest that “expectation of some reciprocal social obligations” are one factor that “should contour the duty to treat.”<sup>26</sup> They hold that the reciprocal social obligations are: 1) provision of adequate protective precautions and equipment to prevent the disease from spreading to caregivers and their families; 2) guarantees of care for professionals who become ill; 3) reduced malpractice threats for physicians who accept the duty to treat; and 4) reliable compensation for the families of caregivers who die in the line of duty.<sup>27</sup>

The professional-society relationship may play a crucial role in determining the presence and scope of a duty to treat. It is especially distressing to read that in Taiwan—and to a lesser extent in Canada—health workers who rose to their professional responsibilities and cared for SARS patients later encountered social ostracism because others in the community feared that they and their families were potential sources of contagion.<sup>28</sup> It may seem quaint to us today to read the section of the American Medical Association 1847 code of ethics that lists ethical duties owed by the patient and the community to the physician. Yet these Taiwanese and Canadian communities failed in their ethical duties to their health workers in a significant way. A society or a community cannot make fearful people act sensibly. But it can express, in no uncertain terms, the appreciation felt toward the workers and the irra-

rationality and indecency of community ostracism.

Reid, as we have seen, accepts the desirability of these reciprocal measures. But she also argues that at least two things are wrong with this standard sociologic model. The first is the dual problem of the threatened balkanization of the different professions and the exclusion of nonprofessional but essential health workers that would undermine the value of solidarity among workers within the health care institution. Second, she claims that the standard model of the “social contract” between society and profession is too constraining. She suggests that the core question is:

### **Social Solidarity and Care of the Vulnerable**

The question of what sort of society we want to live in challenges all of us, including the health professionals, to decide whether we will pull together in the face of pandemic threats, or whether we will allow our communities to deteriorate into what Hobbes called “the war of all against all.” In the United States, the answer so far is that we wish to promote community solidarity when such threats arise. But doubt still remains as to whether by this we mean the entire community, or only those segments of the community that are, under normal circumstances, already

by vulnerable and minority populations.<sup>31</sup>

For these reasons, a critical test of true social solidarity and social justice is whether we are willing to put the needs of vulnerable, underserved populations first. Dr. Margaret Chan of Hong Kong, upon being confirmed as the new head of the World Health Organization in 2007, implicitly suggested such a commitment: “I want us to be judged by the impact we have on the health of the people of Africa and the health of women.”<sup>32</sup>

Two ethical theories converge to require this primary attention to the needs of the most vulnerable. Rawls’s difference principle, a critical component of his overall scheme of “justice as fairness,” stipulates that social and economic inequalities can be justified only when they specifically work to improve the lot of the least-advantaged classes of citizens. To say that a rising tide lifts all boats is not enough. One is obligated to pay attention to the boats that carry the least advantaged to be sure that they indeed rise and are not swamped by the rising waters; otherwise the advantages enjoyed by the yachts of the better-off classes must be condemned as unjust.<sup>33</sup>

A similar view, justified on very different grounds, is conveyed by the teachings of liberation theology.<sup>34</sup> According to this version of Christian moral perspective, people will ultimately be judged primarily according to how well they treat the most vulnerable and neglected among society.

On either of these views, a just system of pandemic preparedness planning would begin by cataloguing all the ways in which vulnerable populations are likely to be neglected and stigmatized. It would then create provisions to prevent those outcomes even before it begins to plan to serve the larger number of more-advantaged people in need.<sup>35</sup> The health professional’s duty to treat is enhanced and deepened when placed upon such a foundation of social solidarity. Health workers now can be confident that they are not tending to

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Does any of us, knowing our own human vulnerability to disease and death, prefer to live in a society that provides healthcare to people with infectious disease, or in a society that leaves epidemics to run their course and devastate the population, or in a society that practices a form of quarantining of the ill without treatment, leaving them to die in isolation?<sup>29</sup>

This more basic question—What sort of a society do we want to live in?—cannot be negotiated between the society and a professional group. It is a question for the society to answer in some fashion as a whole, and professionals must participate in the decision as members of society first and foremost.

best served by both the health care sector and other governmental services. At a time when resources are scarce and the public is eager for scapegoats, vulnerable populations who have all along been least well served by the health care system are in danger of being even further neglected and victimized.<sup>30</sup>

The response to Hurricane Katrina in 2005 is not reassuring in this regard. It seems clear in hindsight that government planning focused on those who had the means to flee on their own. Planning was woefully deficient for those who lacked such means. Within the regional health system, it also seems clear in hindsight that disaster and evacuation planning took inadequate account of the needs and obstacles experienced

the needs of a privileged slice of the population while a much needier group of potential patients has been excluded from their care.

Concern for social solidarity, as evidenced by plans to care for the most vulnerable, returns us to both the procedural values argued for by the Toronto working group, and to one of its substantive values that we have not yet discussed—trust.<sup>36</sup> A common characteristic of populations neglected by the health care system in the past is their greater distrust of that system. This is a potentially dangerous situation in a pandemic. If the public health authorities announce ways to prevent the spread of the emerging infection, but members of the vulnerable community have no trust in these authorities, they are unlikely to act as directed. The lack of trust will lead both to excess death and morbidity in the vulnerable community, and to a reservoir of infection that can spread to other communities as well.<sup>37</sup>

By contrast, suppose that the public health officials are motivated by the model of social solidarity we have described. To assure that the actual needs of the vulnerable are addressed in the preparedness planning, they must engage the community in a process of open dialogue and inquiry. This process, adhering to the five procedural values recommended by the working group, will go a long way toward reestablishing trust between the authorities and the previously neglected communities. Moreover, this approach to preparedness planning will engender a greater level of trust across the entire society. Each person will see that even if he loses his job or his money or whatever status now gives him assurance that he can get what he needs out of the health care system, he will not be neglected in a pandemic. Yet so far, the process of pandemic preparedness planning utilized in the United States and elsewhere fails to include the level of community involvement and dialogue that would lay the groundwork for optimal trust and solidarity

in the face of an infectious outbreak.<sup>38</sup>

### A Duty Shared

A solid ethical basis for the health professional's duty to treat the victims of emerging infectious diseases, even at some level of personal risk, has proven elusive. We began by arguing that some moral obligations of physicians could be discerned as part of an internal morality, rooted in medicine's nature and goals. We stipulated also that this internal morality was not eternal and static, but, rather, responsive to medicine's changing social environment.

A more careful analysis of the duty to treat has provided us with an illustration of what this "social responsiveness" might entail. A full account, we claim, will have to incorporate the various types or levels of social solidarity that are important in a duty to treat. This understanding, in turn, will create a central role for social justice and for the care of vulnerable populations. We also see the importance of social reciprocity in facilitating the virtuous behavior of individual health care workers and their institutions.

The analysis has also shown the limitations of addressing a duty to treat as if it were the exclusive province of any individual health profession. If an institution like a hospital is to respond satisfactorily to a pandemic, a duty to treat will have to be accepted by its physicians, by other health professionals, and by service and support personnel who are not usually viewed as professionals and who have no professional codes of ethics to refer to. We began this discussion with an account of medical morality that encouraged physicians to look inward at the fundamental goals and means that made them a unique profession. If each occupational group in health care looked *only* inward in this fashion, it is very unlikely that we would arrive at a satisfactory conclusion. All health care providers need to look

outward, both at themselves collectively and at society as a whole.

In sum, we have discovered no *single* ethical foundation for a duty to treat that would be commensurate with the needs posed by an emerging infectious disease pandemic. The model of the internal morality of a profession, the historical account of physicians' duties, and considerations of solidarity each provide a necessary element. We have focused on the importance of solidarity because it seems to have been neglected in the literature until quite recently.

The examples of community-wide pandemic preparedness planning with which we are familiar have not, for the most part, been conceived of as exercises in ethics and solidarity-building.<sup>39</sup> The materials we have reviewed on pandemic preparedness too often speak of the need to "instruct" or "educate" health workers or members of the community, rather than engaging them in dialogue in order to consider seriously their views and concerns. We argue that this dimension of preparedness should be emphasized in future efforts. If the more pessimistic predictions of when we may face an avian influenza or similar outbreak are correct, we do not have much time.

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5. Miller and Brody, "The Internal Morality of Medicine: An Evolutionary Perspective." The discussion in that article is restricted to therapeutic medicine and excludes medical research and public health. Our main focus in this article is the duty to treat among physicians (and other health care practitioners) involved in the clinical care of individual patients. Naturally, in a pandemic situation, public health efforts will play a very important role, and cleanly distinguishing the therapeutic from the public-health roles of physicians and nurses will be difficult.

6. The wide range of workers involved is suggested in a recent report by the U.S. Occupational Safety and Health Administration (OSHA): "The delivery of healthcare services requires a broad range of employees, such as first responders, nurses, physicians, pharmacists, technicians and aides, building maintenance, security and administrative personnel, social workers, laboratory employees, food service, housekeeping, and mortuary personnel. Moreover, these employees can be found in a variety of workplace settings, including hospitals, chronic care facilities, outpatient clinics (e.g., medical and dental offices, schools, physical and rehabilitation therapy centers, health departments, occupational health clinics, and prisons), free-standing ambulatory care and surgical facilities, and emergency response settings." Occupational Safety and Health Administration, U.S. Department of Labor, *Pandemic Influenza Preparedness and Response Guidance for Healthcare Workers and Healthcare Employees* (OSHA 3328-05, 2007), 5, [http://www.osha.gov/Publications/OSHA\\_pandemic\\_health.pdf](http://www.osha.gov/Publications/OSHA_pandemic_health.pdf).

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10. J.H. Kim and J.R. Perfect, "To Help the Sick: An Historical and Ethical Essay Concerning the Refusal to Care for Patients with AIDS," *American Journal of Medicine* 84 (1988): 135-38. It seems evident today that the unwillingness of many physicians to treat AIDS victims in the 1980s actually had little to do with the statistical risk of infection, and much more to do with the so-

cial stigma attached to the groups among which the victims were disproportionately found. We will not address this aspect of the historical record. The ways in which diseases like SARS and influenza spread tend to minimize the element of social stigma in the public response to an epidemic, but we should not underestimate the tendency of a society under threat to degenerate into stigmatization and ostracism, as evidenced by recent calls in the United States to exclude illegal immigrants as a potential source of infection.

11. We are grateful to Laurence McCullough for stressing this point in a personal communication.

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14. Pandemic Influenza Working Group, *Stand on Guard for Thee: Ethical Considerations in Preparedness Planning for Pandemic Influenza* (Toronto, Ontario, Canada: University of Toronto Joint Centre for Bioethics, November 2005), [\[utoronto.ca/jcb/home/documents/pandemic.pdf\]\(http://www.utoronto.ca/jcb/home/documents/pandemic.pdf\); L. Reid, "Diminishing Returns? Risk and the Duty to Care in the SARS Epidemic," \*Bioethics\* 19 \(2005\): 348-61. See also University Health Network, University of Toronto, "SARS Key Learnings from the Perspective of the University Health Network: Notes for the Campbell Commission," \[http://www.uhn.ca/About\\\_UHN/what\\\_is\\\_UHN/docs/campbell\\\_presentation\\\_100103.pdf\]\(http://www.uhn.ca/About\_UHN/what\_is\_UHN/docs/campbell\_presentation\_100103.pdf\) \(accessed June 2, 2007\). The entire Campbell Commission report on the Canadian SARS experience can be found at <http://www.sarscommission.ca/report/index.html>.](http://www.</a></p></div><div data-bbox=)

15. Solidarity as a value might also be characterized as an alternative to an exclusive focus on individual rights and choices; see, for example, S.R. Benatar, A.S. Daar, and P.A. Singer, "Global Health Ethics: The Rationale for Mutual Caring," *International Affairs* 79 (2003): 107-138.

16. While quarantine might be the first disease containment strategy that comes to mind, experts on emerging infections such as avian influenza argue that generally more effective strategies might be decreased social mixing and increased social distancing, such as closing large public gathering places, schools, and so forth. Civil confinement, including quarantine, would be a more intrusive measure to be restricted to special needs. See, for example, L.O. Gostin, "Public Health Preparedness and Ethical Values in Pandemic Influenza," in *The Threat of Pandemic Influenza: Are We Ready? Workshop Summary*, ed. S.L. Knobler, A. Mack, A. Mahmoud, and S.M. Lemon (Washington, D.C.: National Academies Press, 2005), 357-71.

17. Singer et al., "Ethics and SARS"; Sokol, "Virulent Epidemics"; E.J. Emanuel, "Do Physicians Have an Obligation to Treat Patients with AIDS?" *New England Journal of Medicine* 318 (1988): 1686-90.

18. Reid, "Diminishing Returns?" Reid herself speaks less of "solidarity" and more of broad vs. narrow social contracts, virtues, and just systems. Nevertheless, we believe that the term is apt.

19. Reid, "Diminishing Returns?" 359. The Canadian SARS Commission agreed: "The health system's capacity to protect its workers was in a state of neglect. . . . There was no system in place to prevent SARS or to stop it in its tracks. The only thing that saved us from a worse disaster was the courage and sacrifice and personal initiative of those who stepped up—the nurses, the doctors, the paramedics and all the others—sometimes at great personal risk, to get us through a crisis that never should have happened. Underlying all their work was the magnificent response of the public at large: patient, cooperative, supportive." *SARS Commission Executive Summary: Spring of*



*Fear*, volume one, 2-3, <http://www.sarscommission.ca/report/v1-pdf/Volume1.pdf> (accessed June 2, 2007).

20. Reid, "Diminishing Returns?"

21. Pandemic Influenza Working Group, *Stand on Guard for Thee*.

22. Chaffee, "Making the Decision to Report"; B.P. Ehrenstein, F. Hanses, and B. Salzberger, "Influenza Pandemic and Professional Duty: Family or Patients First? A Survey of Hospital Employees," *BMC Public Health* 6 (2006): 311.

23. McCullough, "The Physician's Virtues."

24. The OSHA report notes that current assumptions used for a national pandemic influenza strategy include a 30 percent attack rate across the United States. Of those who are ill, half will seek medical attention, and they will have a work absentee rate of up to 40 percent. The report seems to view the 40 percent absentee figure as applying to health care workers along with the rest of the population. OSHA, *Pandemic Influenza Preparedness*, 37-38.

25. Godkin and Markwell, *The Duty to Care*.

26. Huber and Wynia, "When Pestilence Prevails," W9.

27. *Ibid.*

28. M.A. Rothstein, M.G. Alcalde, N.R. Elster, et al. *Quarantine and Isolation: Lessons Learned from SARS. A Report to the Centers for Disease Control and Prevention*

(Louisville, Ky.: University of Louisville School of Medicine Institute for Bioethics, Health Policy and Law, November 2003), <http://louisville.edu/bioethics/public-health/SARS.pdf>; L.M. Hall, J. Angus, E. Peter, et al. "Media Portrayal of Nurses' Perspectives and Concerns in the SARS Crisis in Toronto," *Journal of Nursing Scholarship* 35 (2003): 211-16; D. H-C. Hsin, "SARS: An Asian Catastrophe Which Has Challenged the Relationships between People in Society—My Experience in Taiwan," *Eubios Journal of Asian and International Bioethics* 13 (2003):106-8.

29. Reid, "Diminishing Returns?" 354.

30. Bellagio Group, "The Bellagio Meeting on Social Justice and Influenza. Bellagio Statement," (Baltimore, Md.: Johns Hopkins Berman Institute of Bioethics, July 2006), <http://www.hopkinsmedicine.org/bioethics/bellagio/statement.html>.

31. D.P. Eisenman, K.M. Cordasco, S. Asch, et al., "Disaster Planning and Risk Communication with Vulnerable Communities: Lessons from Hurricane Katrina," *American Journal of Public Health* 97, Suppl. 1 (2007): S109-S115.

32. M. Shuchman, "Improving Global Health—Margaret Chan at the WHO," *New England Journal of Medicine* 356 (2007): 653-56, at 655.

33. J. Rawls, *A Theory of Justice* (Cambridge, Mass.: Harvard University Press, 1971), 75-83.

34. P. Farmer, *Pathologies of Power: Health, Human Rights, and the New War on the Poor* (Berkeley, Calif.: University of California Press, 2003): 139-59.

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38. J. Kotalik, "Preparing for an Influenza Pandemic: Ethical Issues," *Bioethics* 19 (2005): 422-31.

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