

## DIMINISHING RETURNS? RISK AND THE DUTY TO CARE IN THE SARS EPIDEMIC

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### ABSTRACT

*The seriousness of the risk that healthcare workers faced during SARS, and their response of service in the face of this risk, brings to light unrealistic assumptions about duty and risk that informed the debate on duty to care in the early years of HIV/AIDS. Duty to care is not based upon particular virtues of the health professions, but arises from social reflection on what response to an epidemic would be consistent with our values and our needs, recognizing our shared vulnerability to disease and death. Such reflection underwrites a strong duty of care, but one not to be borne solely by the altruism and heroism of individual healthcare workers.*

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SARS placed healthcare workers' lives and health at risk to a degree that has not been seen in generations. It tested public health systems<sup>1</sup> and it tested the courage of many individual medical professionals.<sup>2</sup> Such a crisis also tests the ethical self-understanding of healthcare professionals and the general public: are the stories we tell ourselves about the nature of our moral obligations and the frameworks we employ for moral reasoning consonant with the reality of situations where our obligations come into play and we make moral choices?

Bioethicists and healthcare professionals have debated the duty to care both in particular cases and in its general outlines. The

<sup>1</sup> A. Campbell. 2004. *The SARS commission interim report: SARS and public health in Ontario*. Toronto. Commission to investigate the introduction and spread of SARS in Ontario; D. Walker. 2003. *For the public's health: initial report of the Ontario expert panel on SARS and infectious disease control*. Toronto. Ministry of Health; D. Naylor. 2003. *Learning from SARS: renewal of public health in Canada: a report of the National Advisory Committee on SARS and Public Health*. Ottawa. Health Canada.

<sup>2</sup> D.H. Hsin et al. Heroes of SARS. *Journal of Infectious Diseases* 2004; 49: 210–215.

emergence of HIV/AIDS in the late 1980s was the occasion of a vigorous debate that sought to define the framework for evaluating the existence of a particular duty to care.<sup>3</sup> More broadly, ethicists have reflected on the nature of the duty to care as related to professional virtues or principles, such as beneficence and altruism. Reflection on the experience of healthcare workers during the SARS epidemic offers valuable new lessons about the importance of context in our understanding of the relationship between risk and duty; attention to context is helpful as well in developing a measured understanding of the roles altruism and heroism might play in the social and medical response to an epidemic.

#### THE LEGACY OF THE HIV/AIDS DEBATE: DEFINING ACCEPTABLE LEVELS OF RISK

Debates concerning risk and obligation usually revolve around a certain hypothetical moral agent: an autonomous individual who pursues immediate self-interest by natural inclination and enlightened self-interest by rational conviction. The questions that we might suppose such an autonomous individual would want answered to establish his or her duty to care for infectious patients would be, first, what is the degree of risk entailed by occupational exposure? And second, is that level of risk the same as or lower than the level implicitly accepted in the choice for employment as a healthcare professional?<sup>4</sup>

With such an agent presupposed in the debates around duty to care in the early days of HIV/AIDS, a consensus emerged that any risk comparable to the risk of an infectious disease to which healthcare professionals were already exposed would fall within their duty to care.<sup>5</sup> It was established that the risk was in fact equal to or well below the known risk of Hepatitis B infection (the risk of contraction being much lower but the risk of death if contracted being much higher); such a risk was sufficiently minimal to establish a duty of care for the American Nursing Association,

<sup>3</sup> See for instance G.J. Annas. Legal risks and responsibilities of physicians in the AIDS epidemic. *Hastings Center Report* 1988; 18: S26–S32; J.D. Arras. The fragile web of responsibility. *Hastings Center Report* 1988; 18: S10–S20; D.M. Fox. The politics of physicians' responsibility in epidemics. *Hastings Center Report* 1988; 18: S5–S10; A. Zuger et al. Physicians, AIDS, and occupational risk. *JAMA* 1987; 258: 1924–1928.

<sup>4</sup> See for instance N. Daniels. Duty to treat or right to refuse? *Hastings Center Report* 1991; 21: 36–46; E.J. Emanuel. Do physicians have an obligation to treat patients with AIDS? *NEJM* 1988; 318: 1686–1690. I leave aside the well-known philosophical difficulties of the notion of implicit consent.

but the American Medical Association still had to wrestle with the question of how that duty to accept a certain risk fit with the right they claim as autonomous professionals to accept or reject patients at will. The resolution of the dilemma came through the definition of HIV-infected persons as persons with disability: it would be invidious discrimination to refuse them medical care, according to the AMA's final stand on the issue in 1987.<sup>6</sup>

Huber points out that the duty to care articulated in the HIV/AIDS debate was a weak one, strong enough only to do the political job in the face of HIV/AIDS.<sup>7</sup> Such an appeal to minimal risk, as Freedman argues, leaves open the question of whether healthcare professionals are obligated to accept more than a minimal risk.<sup>8</sup>

According to the framework of the HIV/AIDS debate, obligation sinks with rising levels of risk and there is a level of risk at which the duty to care no longer holds. It is surprising then to read bioethicists presenting the unquestioning assumption of a duty to care on the part of healthcare workers during SARS as an affirmation of the outcome of the HIV/AIDS debate. Emanuel claims that healthcare workers rose to the occasion in SARS as the direct result of the HIV/AIDS debate:<sup>9</sup> as he tells the story, a generation of medical students was brought up under sway of the outcome of the HIV/AIDS debate, hence in full consciousness that adopting their chosen profession implies the willingness to take personal risks in the line of duty. Clark, writing in a similar vein, casually subsumes SARS under 'some degree of risk' that commitment to a medical profession implies.<sup>10</sup> However, if one understands the relationship between risk and obligation as inversely proportionate, as the HIV/AIDS debate claimed, the most striking feature of the SARS epidemic is that healthcare professionals did not abandon their posts *en masse* in the face of

<sup>5</sup> This standard for acceptable levels of risk does not stand up to rigorous philosophical scrutiny: Why should someone's acceptance of a risk level  $x$  imply acceptance of a risk level  $2x$ ? The calculation did establish that the right to turn away an HIV/AIDS patient on the basis of risk was no greater than the right to turn away a Hepatitis B patient, hence giving credence to the charge that refusing care to an HIV/AIDS patient would be an act of discrimination.

<sup>6</sup> B. Freedman. Health professions, codes, and the right to refuse to treat HIV-infectious patients. *Hastings Center Report* 1988; 18: S20–S25.

<sup>7</sup> S.J. Huber et al. When Pestilence Prevails. *American Journal of Bioethics* 2004; 4: W5–W11.

<sup>8</sup> Freedman, *op. cit.* note 6, p. 22.

<sup>9</sup> E.J. Emanuel. The lessons of SARS. *Annals of Internal Medicine* 2003; 139: 589–591.

<sup>10</sup> C.C. Clark. In harm's way. *Hastings Center Report* 2003; 33: inside back cover.

strong evidence that their service placed them at significant risk of illness and death.<sup>11</sup> While healthcare workers in the US actually report a lower level of HIV infection than the general population,<sup>12</sup> and 23% of American residents surveyed would nonetheless, if given the choice, avoid the very small risk of HIV infection,<sup>13</sup> in SARS, anywhere from 3% (in the United States) to 43% (in Canada) of those falling prey to the deadly infectious disease were healthcare workers – with a case fatality ratio of approximately 15%, but much higher for those over 65.<sup>14</sup>

The lesson of SARS is in fact contrary to the conclusion drawn from the HIV/AIDS debate: risk and obligation do not stand in an inverse relationship. The factors playing into ethical decision-making are not exhausted by an ‘implicit contract’ defined by past risk level accepted. A debate about duty to care in the context of an epidemic asks whether it is fair to expect of healthcare workers that they take on a risk of personal injury or death and the burden of psychological stress associated with that risk in order to provide care.<sup>15</sup> There are two constraining features given in the context of such a debate that were not evident during HIV/AIDS. One constraining feature is that the risk has its source in something that does not itself respond to claims of fairness: the biological reality of an epidemic. The individual and autonomous risk-calculator is also a biologically vulnerable human being, and as such encounters risk not only by choice but also by chance. The other constraining feature is the social context: to a significant extent, the risk refused by one individual is left to be absorbed by someone else, whether within the healthcare professions or in the society as a whole. In this sense, the individual and autonomous risk-calculator negotiating a fair distribution of risks

<sup>11</sup> G. Farrow. SARS in health care workers. *CMAJ* 2003; 169: 1147; SE Straus et al. Severe acute respiratory syndrome and its impact on professionalism. *BMJ* 2004; 329: 83.

<sup>12</sup> D.M. Bell. Occupational risk of human immunodeficiency virus infection in healthcare workers: an overview. *American Journal of Medicine* 1997; 102: 9–15.

<sup>13</sup> M.F. Shapiro et al. Residents’ experiences in, and attitudes toward, the care of persons with AIDS in Canada, France, and the United States. *JAMA* 1992; 268: 510–515; D. Smolkin. HIV infection, risk taking, and the duty to treat. *Journal of Medicine and Philosophy* 1997; 22: 55–74.

<sup>14</sup> World Health Organization. 2003. *Consensus document on the epidemiology of severe acute respiratory syndrome (SARS)*. Geneva. World Health Organization.

<sup>15</sup> Literature on the psychosocial effects of SARS on healthcare workers includes S. Chan. Nurses fighting against severe acute respiratory syndrome (SARS) in Hong Kong. *Journal of Nursing Scholarship* 2003; 35: 209; R. Maunder et al. The immediate psychological and occupational impact of the 2003 SARS outbreak in a teaching hospital. *CMAJ* 2003; 168: 1245–1251; K. Sim et al. The psychological impact of SARS. *CMAJ* 2004; 170: 811–812.

does confront agents who do respond to claims of fairness, but these agents *ipso facto* assert their own claims of fairness in turn.<sup>16</sup>

Writers in the HIV/AIDS debate imagined that the limits of obligation would be reached when we reached a certain level of risk. SARS took us to vastly increased levels of risk, but at the same time showed that risk is both biologically given and socially distributed. The choice is not between past risk levels and current risk levels, but between accepting current risk levels and passing them on to someone else – and particularly because of the elevated risk for healthcare workers, that ‘someone else’ in SARS was not a hypothetical doctor, whom the HIV-positive patient was left to find on his own, but a known colleague in the hospital setting. SARS did raise the question of duty to care for each individual healthcare worker but *ipso facto* raised the question: if not me, then who?

Such a question points to the issue of distribution of risk within the healthcare community. It also points to the broader question of the social response to medical necessity: if physicians and nurses do not care for those who are critically ill, then who will? Is there supposed to be some other group in our society who are more appropriately trained and more deeply obligated to serve in case of a medical emergency? If the choice instead is for quarantine and abandonment to death, then on what basis are the military or police, who presumably would carry out such a policy, any more obligated to risk their lives in carrying it out than medical personnel are obligated to risk theirs in providing care?

#### PROFESSIONALISM AND DUTY TO CARE: BROADENING THE SOCIAL CONTRACT

It has been argued traditionally that the special commitment of doctors to a high standard of altruism and beneficence, and hence to a duty to care even at risk to themselves, is one side of the social contract between the profession and society at large. Contracts offer benefits in exchange for services rendered: the benefits doctors seek in exchange for recognizing a duty to care have been proposed to be self-regulation,<sup>17</sup> or the high status and

<sup>16</sup> While I present no gender analysis in this essay, this perspective is learned from feminist bioethics. See S. Sherwin. A relational approach to autonomy in health care in S. Sherwin and the Feminist Healthcare Ethics Network, eds. 1998. *The politics of women's health: exploring agency and autonomy*. Philadelphia. Temple University Press: 19–47.

<sup>17</sup> C.C. Clark. Trust in Medicine. *Journal of Medicine and Philosophy* 2002; 27: 11–29.

generous remuneration of the profession, such as it is in wealthy societies. Clark, for instance, writing from (but not officially on behalf of) the ethics office of the AMA, praises the selfless service of doctors in the face of SARS,<sup>18</sup> but alerts us in the subsequent exchange of letters<sup>19</sup> that this service is perhaps not as selfless as it appears: he characterizes this 'selfless service' as something of a bargaining tool, and claims that the good that doctors bargain for with this service is their status as independent practitioners, self-regulating, and beholden to no outside social body. This issue of professional self-image played a role in the HIV/AIDS debate, as we saw, making it more difficult for the AMA than the ANA to arrive at a policy statement affirming duty to care. The determination of some physicians to preserve their independent status and avoid any arrangement that might turn them into 'employees' makes it difficult for them to accept politically an articulation of a duty to fulfil social needs at all. It is more agreeable, after all, to do good out of generosity than because one is expected or compelled to.<sup>20</sup>

While such arguments present self-regulation and status as the professional privileges offered in exchange for physicians' trust-inspiring recognition of the duty to care, surely the professional privilege most relevant to duty to care is exclusive scope of practice. Why would society grant exclusive scope of practice in relation to an essential human service to a professional group not prepared to guarantee provision of that service in an emergency? The social contract forming the professions leaves us no one but licensed healthcare professionals to turn to in an emergency.

While the existence of exclusive scope of practice speaks for a strong duty to care, it does not capture the whole basis of duty to care. An approach that focuses on the social contract defining the physicians' profession neglects the fact that doctors are not the only ones who are called upon to accept risk and psychological distress while serving in the face of an infectious epidemic like SARS. Nurses, paramedics, and hospital janitorial staff served and died alongside doctors in the SARS epidemic.<sup>21</sup> A basis for duty to care founded only on doctors' or other licensed health professionals' narrow professional self-interests would be inadequate to

<sup>18</sup> Clark, *op. cit.* note 10.

<sup>19</sup> C.C. Clark. Reply. *Hastings Center Report* 2004; 34: 4.

<sup>20</sup> Some data on medical students' appreciation of this point: F.W. Hafferty. What medical students know about professionalism. *Mount Sinai Journal of Medicine* 2002; 69: 385–397.

<sup>21</sup> D. Koh et al. SARS: health care work can be hazardous to health. *Occupational Medicine* (London) 2003; 53: 241–243.

underwrite the provision of healthcare more broadly. It would also give doctors a motivation for purportedly moral actions that is in fact very thin. Is it plausible that a commitment to the one form of professional governance over another would be a stronger motivation for risk-taking than a commitment to patients or to a social vision about the value of caring for the ill?<sup>22</sup>

A more basic and universal social contract emerges from reflection on the following question: 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 practises a form of quarantining of the ill without treatment, leaving them to die in isolation?<sup>23</sup>

The advantage of recognizing a broader social contract underlying the duty to care is that it brings all involved in supporting, maintaining, and running a healthcare facility under its umbrella, so that we can recognize that all healthcare workers – from medical to administrative to maintenance staff – face a common risk and burden of psychological distress, and face relevant moral dilemmas. Indeed, some of them face these dilemmas with less luxury of choice, less economic and social reward, less information and hence less safety derived from information, than the doctors whose special moral obligations bioethicists have traditionally sought to define.

In addition, such basic social reflection extends to the general public in our role of supporting the healthcare system both during an epidemic and in times where there is no crisis. The public supports a world where the ill are cared for when they pay taxes or vote for governments that support the healthcare system, or pay into an insurance fund. Similarly, we support the provision of care in an epidemic when we trust public health's risk assessment enough to greet and shake the hand of our neighbour who works in healthcare and is not in quarantine. Healthcare workers felt it deeply when their neighbours avoided and isolated them and their families.<sup>24</sup> We expected them, at considerable personal risk, to trust public health and infection control measures in accepting

<sup>22</sup> Several physicians who commented on drafts of this paper found distressing the suggestion that duty to care was a professional trade-off rather than a response to human need.

<sup>23</sup> The Kantian (universalizing) style of the reflection invited in this question is evident.

<sup>24</sup> L.A. Nickell et al. Psychosocial effects of SARS on hospital staff. *CMAJ* 2004; 170: 793–798; D. Walker. *op. cit.* note 2, pp. 175–176.

their workplaces as 'safe enough' under the circumstances; when the general public informally quarantined those who were not quarantined, we failed to extend such trust, at very slight risk to ourselves, to express our support of them in concrete and human ways. In doing so, we violated what ought to be a shared commitment to enacting a social value.

#### VIRTUES, PRINCIPLES, AND DUTY TO CARE: HEROISM AND ALTRUISM

It is undeniable that healthcare workers exhibited the virtues of heroism and altruism in the face of danger during the SARS epidemic. Nonetheless, a critical perspective is needed on the theoretical and practical work we expect personal commitment to high moral standards to do. Are altruism and heroism particular virtues of medical professionals? What role should we expect them to play in ensuring care during infectious epidemics?

In a paper that set the tone for decades of debate in ethics, J.O. Urmson argued that moral theory needs to be able to make the distinction between the good that we expect of one another (our duties) and the good that one may hope for or aspire to or admire in others but that is above and beyond the call of duty and outside the realm of ordinary socially-enforced obligations, i.e. the supererogatory.<sup>25</sup> Although Urmson intended the example of heroism to make a meta-ethical point by establishing the existence in ordinary moral thought of a category awkward for philosophy, philosophers responded by vigorously debating the existence, character, and implications of the supererogatory: the heroic or saintly as such came under critical scrutiny.

Some philosophers who might be counted as advocates of heroism have argued that Urmson was mistaken in claiming that the actions of saints ought not of necessity inspire us to emulate them, either to do acts that express the same virtues though perhaps more modestly than the extreme acts of heroes,<sup>26</sup> or to become heroes ourselves.<sup>27</sup> Others have argued for a more critical attitude towards the heroic, arguing that supererogatory acts are not always commendable,<sup>28</sup> that the heroes and saints who perform them are not necessarily exhibiting a superior variant of

<sup>25</sup> J.O. Urmson. 1958. Saints and heroes. In *Essays in moral philosophy*. A.I. Melden, ed. Seattle. University of Washington Press: 198–216.

<sup>26</sup> E.M. Pybus. 'Saints and Heroes'. *Philosophy* 1982; 57: 193–199.

<sup>27</sup> D. Heyd. 1982. *Supererogation*. Cambridge. Cambridge University Press.

<sup>28</sup> J. Hampton. Selflessness and the loss of self. *Social Philosophy and Policy* 1993; 10: 135–165.

ethical agency,<sup>29</sup> and, following Kant, that an ethical theory that places an emphasis on heroic acts endorses a dubious form of ethics where one makes up for day to day neglect of duty with the occasional large magnanimous gesture.<sup>30</sup> Saints may be bent on developing their own moral perfection to the point where other important human qualities are lost. Acts that appear to be supererogatory may be foolish, self-destructive, or indicative of a lack of healthy self-esteem.

Urmson himself distinguished the doctor who works long hours and tends to her fiduciary obligations in the ordinary course of her practice, i.e. the doctor acting out of duty where the duty of the profession is (arguably) onerous in comparison with other professions, from the doctor acting above and beyond the call of duty in joining Doctors Without Borders. While philosophers are circumscribed and critical in their discussions of supererogation, and distinguish beneficence as a professional virtue of medicine from a heroic degree of beneficence, some bioethicists and healthcare professionals have taken up the notion of supererogation to argue that doctors should understand their adoption of the profession as the adoption of a supererogatory level of commitment to the altruistic ideals of medicine,<sup>31</sup> even to the point of arguing that accepting pay for one's work is dubious and taking holidays suspect.<sup>32</sup>

R.S. Downie, on the other hand, has long disputed the notion that doctors have a special moral calling, and that the practice of medicine is in any sense especially beneficent or altruistic. We expect our doctors to work to the best of their ability to benefit rather than harm us just as we expect this of our auto mechanics, and the fact that they are reasonably remunerated for their efforts means that it strains language to describe the practice of medicine in itself as 'altruistic.'<sup>33</sup>

<sup>29</sup> S. Wolf. Moral saints. *Journal of Philosophy* 1982; 79: 419–439.

<sup>30</sup> M. Baron. Kantian Ethics and Supererogation. *Journal of Philosophy* 1987; 84: 237–262.

<sup>31</sup> A.C. McKay. Supererogation and the profession of medicine. *Journal of Medical Ethics* 2002; 28: 70–73; S.A. McLean. Commentary on Glannon and Ross, and McKay. *Journal of Medical Ethics* 2002; 28: 74.

<sup>32</sup> D.C. Thomasma et al. A dialogue on compassion and supererogation in medicine. *Cambridge Quarterly for Healthcare Ethics* 1995; 4: 415–425.

<sup>33</sup> See R.S. Downie. Supererogation and altruism: a comment. *Journal of Medical Ethics* 2002; 28: 75–76, and Downie and Gillon's lively 1986 exchange in the pages of the same journal: R.S. Downie. Professional ethics. *JME* 1986; 12: 64–66; *JME* 1986; 12: 195–196; R. Gillon. More on professional ethics. *JME* 1986; 12: 59–60; Do doctors owe a special duty of beneficence to their patients? *JME* 1986; 12: 171–173. W.C. McGaghie et al. Altruism and compassion in the health professions. *Medical Teacher* 2002; 24: 374–378.

It is not uncommon to identify ethics entirely with one's obligations to others, in effect construing one form of moral failure (selfishness) as expressing the basic character of all moral failure. Judith Andre has argued, contrary to this assumption about the nature of morality, that one's obligations to oneself are no less moral in character than one's obligations to others.<sup>34</sup> Just as one can be unjust towards others, or dishonest with them, so one can be unjust towards oneself, or dishonest with oneself, and that would constitute moral failing. Carol Gilligan has argued that there are two directions of moral growth: for the person to whom self-regarding actions come more easily, to learn to take the needs of others into account; for the one to whom other-regarding actions come more easily, to learn to treat oneself as equally worthy of care and respect.<sup>35</sup>

The supererogation debate alerts us to the dangers of heroism; other developments in moral philosophy offer a tempered view of altruism. The fabled noble sacrifice of doctors in eras past may have come at too high a cost to family commitments and personal health.<sup>36</sup> Medicine is for the most part no longer practised by individual doctors in private settings; emergency care in a deadly epidemic in particular could never be handled on such a model. The provision of healthcare is the task of a complex sector involving many agents. Where the culture at large once expected the individual charity of individual doctors to meet the healthcare needs of those who might otherwise go without treatment for financial reasons, insurance systems, governments, and taxpayers have taken on the responsibility of enabling access to care by means that do not require healthcare professionals to face a stark conflict between the promptings of conscience and the necessities of earning a living. We also need systems-level responses to the needs of those who may go without treatment for reason of the danger of infection that they pose to others. To treat the duty to care as a matter of individual moral commitment to altruism, beneficence, or supererogatory action is to ignore the responsibility we all share to create and maintain structures that support people in fulfilling their duties as healthcare professionals and workers in the healthcare sector.

<sup>34</sup> J. Andre. The equal moral weight of self- and other-regarding acts. *Canadian Journal of Philosophy* 1987; 17: 155–166.

<sup>35</sup> C. Gilligan. 1993. *In a different voice*. Cambridge, Mass. Harvard University Press.

<sup>36</sup> M. Winerip. Did you hear about Doc Ogden? *New York Times Magazine*. May 5, 2004; 42.

These considerations do not imply that healthcare workers ought to be selfish rather than altruistic, but that the simple opposition between altruism and selfishness impedes rather than aids our understanding of duty to care. Nor is it to deny that the challenge SARS posed for the healthcare system was in fact met by acts of heroism and altruism on the part of healthcare professionals and all workers involved in the operation of the healthcare system, or even to claim that such crises can be met without heroes. The point is rather to place these acts of heroism in a broader context where the strengths and limitations of heroism can be appreciated. Posing the issue of duty to care solely in terms of an obligation to others in conflict with self-interest<sup>37</sup> fails to capture the real moral dilemmas faced by healthcare workers in an infectious epidemic.

While accepting risk in the line of duty was not controversial among healthcare workers during SARS, moral dilemmas arose for those who felt their obligations as healthcare professionals conflicted with their obligations to others as family members and caregivers.<sup>38</sup> In addition, infection control measures were not only physically stressful,<sup>39</sup> but also gave staff the very difficult requirement, contrary for many of them to temperament and to their training in professional ethics, that they delay or deny treatment to patients in order to take the time to suit up and protect themselves.<sup>40</sup> Identification of duty to care with altruism makes invisible moral conflicts between the various parties to whom a person may owe care, and interferes with the need of healthcare professionals to understand and accept that they must take all possible measures consistent with the social need for a functioning healthcare system to protect themselves in an epidemic. The obligation to noble self-sacrifice seems incompatible with insisting on proper protective equipment and psychologically sustainable working arrangements.<sup>41</sup> Medical ethics should not make invisible that learning to care for oneself can for some people at some moments be an ethical task, in the way we more commonly assume that learning to care for others is, and that acting in

<sup>37</sup> See, for instance, R. Jones. Declining altruism in medicine. *BMJ* 2002; 324: 624–625.

<sup>38</sup> M. Bernstein et al. Challenging beliefs and ethical concepts. *Critical Care* 2003; 7: 269–271; Nickell et al., *op. cit.* note 24; P.A. Singer et al. Ethics and SARS. *BMJ* 2003; 327: 1342–1344.

<sup>39</sup> Nickell et al., *op. cit.* note 24.

<sup>40</sup> Straus et al., *op. cit.* note 11; Bernstein et al., *op. cit.* note 38.

<sup>41</sup> B. Sibbald. Right to refuse work becomes another SARS issue. *CMAJ* 2003; 169: 141.

concert with others to ensure that the group to which one belongs is not unfairly burdened can likewise be the expression of a social value that is to be lauded.

I have argued above that the duty to care arises from a broad rather than narrow social contract: the systems that care for the ill, both in the ordinary course of things and in epidemics, are the creation of a broad range of workers and stakeholders. If we as taxpayers vote consistently for governments that cut healthcare budgets, or as consumers in market systems make choices that drive healthcare professionals into unsustainable working situations – and then expect the individual, morally-mandated heroic effort of overworked healthcare workers in over-burdened systems to save us from the consequences of such policies and choices in the event of emergencies, then we are not fulfilling our duties as a society. 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. The ordinary course of life and the contingencies of natural and biological disasters can generally be counted on to supply a sufficient number of opportunities for supererogatory deeds, however much support we offer healthcare workers.

## JUST SYSTEMS

We need a range of ethical concepts that enable us to distinguish social and individual decisions, and to relate the social and the individual in a sophisticated and realistic manner. To consider the social question is to ask what range of options we have for response as a society to infectious epidemics. What is our ideal? In SARS we were able to approximate an ideal in which full medical care was provided for all those who fell ill. What would be the constraints that might, in more severe situations, prevent us from attaining that ideal? Those constraints include but are not limited to the degree of risk to which individual workers within the healthcare system are prepared to subject themselves. Crucially, they will include weighing the possibilities against alternative options and the costs of those alternatives, a theme

remarkably absent from the HIV/AIDS debates.<sup>42</sup> What are the consequences of not providing medical care to the ill? Who would manage the spread of an epidemic if healthcare professionals could not do so, how would they manage it, and how would we understand their obligations to do so?

The question of how that risk is to be distributed is a complex mix of pragmatics and considerations of justice: Fox reminds us that traditionally epidemics have not been met with the expectation that all doctors serve equally, but with the financing of cadres of 'plague doctors,' or with the exploitation of existing pools of military medical personnel (in the flu epidemic after the First World War) who are habituated to following orders and accepting risk.<sup>43</sup> During SARS, the hospitals adopted a variety of voluntary and compulsory means of fulfilling their duty to care for SARS patients.<sup>44</sup>

Within a social response to infectious epidemic, decisions on the individual level and the ethics of these decisions remains a live topic: what levels of risk are we prepared to ask individuals to suffer, and what levels of risk are they or we prepared to accept? How much risk individuals are prepared to assume will depend less on the past level of risk assumed than the HIV/AIDS debate led us to believe. SARS taught us that elevated levels of risk strengthen rather than weaken duty to care – insofar as the question is one of a social distribution of a biologically-given risk within the workplace, and in society at large.

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<sup>42</sup> A substantive consequentialist argument around duty to care in HIV/AIDS did not emerge until 1997, in Smolkin, *op. cit.* note 13, p. 61.

<sup>43</sup> Fox, *op. cit.* note 3, pp. S5–S10.

<sup>44</sup> Sibbald, *op. cit.* note 41, p. 141.

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