From the Fall 2003 Newsletter

POLICY PERSPECTIVES

The Administrator's Dilemma

by Matthew K. Wynia, MD, The Institute of Ethics, AMA
and
Bette-Jane Crigger, PhD, National Center for Ethics in Health Care

Health care administrators responding to infectious disease face not only clinical but ethical challenges. They must balance sometimes competing responsibilities to patients, the public, and staff.

Consider the recent SARS outbreak. The Centers for Disease Control and Prevention (CDC) has established clinical guidelines for managing potential SARS exposures in health care settings. The CDC generally recommends that institutions take steps to prevent unprotected exposure of staff, establish mechanisms for surveillance of health care workers who have contact with SARS patients, monitor employee absenteeism for signs of emerging infection, and isolate staff who have had unprotected, high risk exposure (http://www.cdc.gov/ncidod/sars/exposureguidance.htm). As the probability of actual exposure increases, the stringency of specific CDC recommendations also increases, because of the increasing risk to patients, the public, and fellow health care workers. But measures such as isolation and quarantine not only pose significant logistic challenges and can take a heavy toll on material and human resources, there are important ethical considerations at stake as well. Organizational leaders must balance duties to protect the public welfare, provide appropriate care for *all* patients, *and* respect the well-being, rights, and dignity of health care workers.

Physicians (and other health professionals) have long subscribed to explicit codes of ethics that demand the duty to treat,[1,2] which the public assumes to be binding. In 1991, despite inter-professional wrangling over treatment of patients with HIV, 72% of the public agreed with the statement that physicians are obligated to "treat all sick people."[3] The American Medical Association reaffirmed this obligation in a *Declaration of Professional Responsibility* adopted in December 2001, which states that physicians must "treat the sick and injured with competence and compassion and without prejudice," and "apply our knowledge and skills when needed, though doing so may put us at risk."[4]

In tandem with health care professionals' duty to treat in the face of personal risk, however, health care institutions have responsibilities to take reasonable steps to minimize those risks, including, for example, ensuring that health care workers have ready access to vaccines (when they exist), safety training, and appropriate protective technologies (such as N95 respirators). They also have obligations to provide appropriate treatment for those health care providers who succumb to infection.[5] As the CDC SARS guidelines make clear, however, administrators'

obligations can come into conflict. Policies and procedures, such as exclusion from duty or surveillance, intended to protect both patients and staff, also risk being burdensome and intrusive. Designating the period of exclusion from duty as personal leave, say, rather than administrative absence, would take unfair advantage of health care workers who have undertaken risks on behalf of patients and the public. Such a policy would also be a *dis*incentive to reporting exposure, rendering isolation less effective as a protective measure, and might even prompt some to refuse to care for patients with known or suspected infection. Similarly, staff under surveillance for symptoms are owed no less respect for privacy and dignity than is shown to patients. In addition, efforts should be made to assure that surveillance measures are efficient and unobtrusive when possible. In Toronto during the SARS outbreak, hospital staff had temperature recordings taken as they swiped their bar-coded employee cards to check in for work.[6]

Finally, while the duty to treat is core to health care professionalism it does not obligate an individual health care professional to take excessive risk or bear disproportionate burdens—that is, it is not an obligation of martyrdom.[1] The institutional ethical corollary is that health care facilities have an obligation to enable individual staff to avoid undue risk posed by unusual personal circumstances to the greatest extent possible. Institutions should make reasonable efforts to assure coverage so that when caregivers (and/or other staff) are grouped or “cohorted” to minimize the number of staff exposed to (potentially) contagious patients, consideration should be given to avoiding undue risk or personal hardship for individual providers. It is reasonable to provide back up staff and excuse insofar as possible individuals who are pregnant, who have dependents at home, or for whom such duty would pose other special challenges.[7]

References:

[1]Arras JD. The fragile web of responsibility: AIDS and the duty to treat. Hastings Cent. Rep. 1988;18(2):suppl. 10–20.

[2]Daniels N. Duty to treat or right to refuse? Hastings Cent Rep 1991;21(2):36–46.

[3]Roper. Great American TV Poll #4, vol. 2002. Princeton Survey Research Associates, 1991.

[4]American Medical Association. Declaration of Professional Responsibility: Medicine's Social Contract with Humanity. Chicago: American Medical

Association, 2001. Available at http://www.ama-assn.org/go/declaration. Accessed August 11, 2003.

[5]Wynia MK, Gostin LO. Ethical challenges in preparing for bioterrorism: The role of the health care system. (manuscript in review).

[6]Altman LK. Behind the mask, the fear of SARS. New York Times 2003;June 24.

[7]Downey K. Nurses brace for SARS. Washington Post 2003;June 10.