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BEST PRACTICES

A Duty to Treat

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The outbreak of severe acute respiratory syndrome (SARS) is over, for the moment. That gives us an opportunity to reflect on the lessons this and other infectious diseases have taught us about the ethical aspects of health care and public health, as well as the extent and limits of the “duty to treat.” And it gives us an opportunity to think about how those lessons should guide us in our, inevitable, next encounter.

Many lessons have been clinical. Tuberculosis, for example, pushed us to develop new isolation methodologies; HIV made “universal precautions” routine in good clinical practice; hepatitis B brought prophylactic vaccination to protect health care workers, while flu prompted vaccination of caregivers to protect themselves and high-risk patients. The threat of bioterrorism has led us to ask to what we can expect health care professionals, absent specific contraindications, to accept the significant risks of smallpox vaccination in the cause of being “first responders.”

We’ve learned that we must think about infection control beyond the individual level if we are to protect our patients, our colleagues and employees, and our health care system.

Other lessons have been ethical. We’ve learned that our efforts to prevent, control, and treat infectious diseases raise important moral concerns. For example, today we recognize that we must balance obligations to protect the health of third parties with obligations to respect the rights and civil liberties of individuals who are infected/have been exposed to disease. And how compulsory directly observed therapy runs up against the right to refuse treatment that patients enjoy in other contexts. We’ve come to understand how mandatory reporting poses challenges for privacy and confidentiality and how, in the presence of social stigma, it can create a perverse incentive for individuals not to disclose or seek care, hampering efforts to improve prevention and treatment.

Among the significant ethical issues posed by infectious disease have been what AIDS physician Abby Zuger called “physician-oriented issues.” That is, questions about health care providers’ rights and obligations as practitioners. What risks can we justifiably expect clinicians to take? And what can we require them to do to protect themselves so that they can serve others?

Consider tuberculosis, for example. TB is an airborne infection that is sometimes transmitted by individuals who do not show clear symptoms. To protect health

care workers and other patients, accepted occupational health practice is regular PPD testing of all appropriate health care workers to see if exposure to tuberculosis has occurred. Or think about HIV. Early in the AIDS pandemic, we learned—or rather, painfully rediscovered—that health care can be a very risky profession. SARS is teaching the same hard lesson. In fact, one of the clinician-epidemiologists who first described and documented SARS contracted the infection. Dr. Carlo Urbani of WHO died trying to alert the health care community to this new infectious disease. During the second wave of SARS in Toronto between April 15 and June 9 this year, 29 (39%) of 74 reported cases were among health care workers.

When HIV emerged twenty years ago, we found ourselves as ill prepared to address the implications for clinicians as we were to prevent or treat the new, apparently lethal, blood-borne disease. We faced stark questions about the limits of professional obligations—may health care professionals ethically decline to treat a patient known or thought to be seropositive for human immunodeficiency virus? Or do physicians, nurses, or other caregivers have a duty to accept personal risk of infection as a condition of professional practice?

The answer to the ethical question, “Is there a duty to treat?” is yes. Several arguments support that duty. As *professionals*, health care providers are held to a higher standard of conduct than are other people. The obligation to care for the vulnerable, even at some personal risk, is deeply rooted in medicine’s moral core. The duty isn’t absolute—physicians can refuse to treat a patient because they lack specific competence, for example, but neither is it optional—they cannot refuse to treat because the patient “poses some hazard.”

The duty to treat also rests on medicine’s “social contract”: in exchange for their services to patients and society, health care professionals enjoy the privilege of professional autonomy in being self-governing, as well as enjoying high social status, public respect, and, often, substantial income. In voluntarily joining a profession dedicated to putting the interests of others first, health care providers cannot avoid the “hazardous duty” clause of that social agreement.

The duty to treat is not without limits, of course. No one expects physicians, nurses, physicians’ assistants, nurse practitioners, or other health care professionals to take irrational risks or make unreasonable personal sacrifices for the sake of patients or the public. There must, at minimum, be some foreseeable benefit to the patient; and caregivers need not go out of their way to confront danger.

Just as we did with HIV/AIDS, as we learn more about SARS, we will be better able to reduce the risks to health care professionals. Already, we recognize that some procedures should only be performed by highly qualified staff; and we are exploring protective technologies. And the more we learn about the epidemiology, etiology, and treatment of SARS, the more clearly we will be able

to characterize and minimize the risk to providers. What may seem excessive in the environment of uncertainty in the early days of an epidemic may come to appear more acceptable in the light of greater knowledge.

But some measure of risk “comes with the territory” in being a health care professional. And for VHA clinicians, that territory is populated by veteran-patients who have themselves run substantial risks for the benefit of others.

Readings and Resources:

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