Caring for risky patients: duty or virtue?

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ABSTRACT

The emergence several years ago of SARS, with its high rate of infection and death among healthcare workers, resurrected a recurring ethical question: do health professionals have a duty to provide care to patients with deadly infectious diseases, even at some substantial risk to themselves and their families? The conventional answer, repeated on the heels of the SARS epidemic, is that they do. In this paper, I argue that the arguments in support of such a duty are wanting in significant respects, and that the language of duty is simply not adequate to an understanding of all the moral dimensions of professional responses to the care of risky patients. Instead, we should speak the language of virtues and ideals if we want to do justice to the complexity of such harrowing circumstances.

The limits of the duty to treat

To appreciate the role played by ideals and virtues, we need first to understand where the language of duty fails us. We’ll uncover two limitations. First, the arguments for a duty to treat can at most establish that only some physicians have such a duty, and only under particular circumstances. And yet even when duty is unclear, we still need some moral framework for understanding physicians’ responses to risky patients. Second, the language of duty fails at the very moment when we most want to invoke a “duty to treat”—at the outbreak of a new and deadly disease—and so leaves us with no terms for morally evaluating professional behaviour under these circumstances. Only the language of virtue gives us something more to say.

The social contract argument

The most common argument for a duty to care for risky patients is a contractual one. Society bestows special privileges (of licence monopoly, social status, income, tax support for professional training and so on) on health professionals, physicians especially. In return, society rightfully expects that those of its members who are ill will receive the care they need (well, in the USA, at least if they can pay for it). Huber and Wynia note that “the duty [to treat] implies reliance on physicians to perform according to a social contract, for which physicians as a group are rewarded and, by extension, the breach of which is anticipated to lead to rescinding of professional prerogatives granted the group by society.”

The social contract argument must confront a simple question. Is the contract between society and the profession, or between society and each professional? Either way, it fails to establish that a duty to treat is incumbent on every professional.

If the social contract is with the profession as a whole, the problem is that the terms of the contract don’t require that each and every professional be ready to provide care to any patient who might come before them. The profession’s end of the bargain is kept so long as there are enough physicians willing to provide care that the needs of SARS or other risky patients are met. There is no duty to care for risky patients that is borne by every physician. Individual physicians’ decisions not to care for these patients are compatible with the profession’s duty to treat so long as those decisions don’t undermine the collective ability to provide the care that is needed.

If the contract is with each individual professional, then we have to ask when and how each of them entered into such an agreement. Alexander and Wynia report that around one-fifth of physicians would be unwilling to care for patients with...
“an unknown but potentially deadly illness,” and that their unwillingness increases as the known risk becomes greater. Moreover, 45% of their sample denied that physicians have a duty to provide care in epidemics when that endangers the physician’s health (p193). Given this diversity of opinion on the matter, it strains credibility to claim that every physician has consented to take significant risks as a condition of licensure. (See Smolkin for similar arguments against contract theories.)

The “defining values” argument
Sometimes it is argued that the duty to care for risky patients is inherent in the health professional role. Masur, Emanuel and Lane wrote that

... physicians and nurses have an obligation to treat sick and potentially infectious patients because they are members of a profession whose primary goal is an ethical calling: caring for the sick. This obligation to serve the sick is constitutive of medicine as a profession and is uniquely what distinguishes physicians, nurses, and other clinicians from other professionals.

And so avoiding SARS or other risky patients is a basic betrayal of professional identity.

The problem is that those who avoid these patients haven’t stopped their practice of medicine. They’re still caring for lots of sick people, just not people sick with SARS. One needn’t always be taking significant risks to care for the sick.

The argument has more bite when it is applied to those who have chosen specialties that inherently carry additional well-known risks with them. Infectious disease is the obvious example of a specialty whose very identity involves taking risks. So it may indeed show that such physicians do have a special duty to take risks—still a far cry from establishing that all physicians have one.

The firefighter analogy
Often these two arguments are combined in an analogy between medicine and other risky professions (for example, see Masur, Emanuel and Lane). A physician is like a firefighter. We don’t think firefighters can excuse themselves from getting on the truck when the alarm sounds, or from entering a burning building to search for those trapped inside. Such behaviour imperils the success of the mission which fire departments are created to serve. You can’t be a firefighter if you can’t serve the mission; and you can’t serve the mission unless you are prepared to take substantial risks.

The analogy proves too little. It imposes a duty on physicians to take risks only when their failure to do so imperils the mission (for example, endangers adequate patient care). But since there are circumstances in which a particular physician’s avoidance of particular patients with SARS would not imperil the mission, the duty implied by the analogy is not a minimal duty borne equally by all.

My objections against these first three arguments for a duty to treat don’t imply that there never is a duty to take risks in caring for patients—only that it is a secondary duty contingent on circumstances in which other duties are at stake. So there may be a duty to treat when failure to do so significantly endangers patients’ lives or welfare, or when failure to do so places an unfair burden of additional risk on other providers. When these conditions don’t obtain, there is no duty to provide care that places oneself at risk. The very phrase “duty to treat” obscures the central importance of these other duties to any obligation to take risks on behalf of patients. It also obscures other moral perspectives that might equally well explain the disquiet felt when physicians avoid taking on the care of risky patients, even when no one is the worse for it.

A look at one last argument for the duty to treat reveals just why we need more than the language of duty.

The consistency argument
Caring for sick people carries some minimal background level of risk, and anyone unprepared to assume that background risk couldn’t practice medicine. At least this much risk-taking is inherent in the professional role. Once this is admitted, the argument asserts that like cases should be treated alike: I can’t justify a decision not to provide care to a patient with an infectious disease when the risk is substantially comparable to the background risk I routinely assume.

This type of argument was routinely used with great effect against refusals to care for patients with HIV, when it was pointed out that those refusing to provide such care were none too routinely risking exposure to hepatitis B, which is very much more infectious, and which causes more deaths from occupationally acquired infection than HIV ever has.

Despite the rhetorical power of the argument for consistency in those circumstances, it is a poor basis for asserting a general duty to care for risky patients. It concedes by definition that it is not a duty, but an act of courage, to care for patients with SARS or other diseases whose lethality and infectivity are higher than “average”. It is inconvenient that these are exactly the conditions when one might want to most vigorously assert a professional duty to take risks. As Reid points out, under the logic of the argument, “the most striking feature of the SARS epidemic is that healthcare professionals did not abandon their posts en masse in the face of strong evidence that their service placed them at significant risk of illness and death.”

The problem here is related to the question of what the limits are on a duty to take risks for patients. All advocates of a duty to treat agree that the duty is not absolute: there are levels of risk that lie beyond any professional obligation. Unfortunately, the various arguments for a duty to treat offer no resources for figuring out what its limits are. As the risk continues to increase beyond the background level, we become less and less certain about what duty requires. In situations of great uncertainty, during the initial outbreak of an epidemic, say, we will be uncertain as well whether any duty applies at all.

I’ve argued that the language of duty quickly runs out of things to say about decisions to avoid the care of risky patients when more fundamental duties are not at stake, and when risk, or its uncertainty, lies outside the everyday. These claims are typically greeted with disbelief. Surely there’s something wrong, for example, with paediatricians who quietly sit on their hands when volunteers are needed to provide care for a young girl infected with monkeypox, and let other members of their group step forward. Since surely there’s something wrong, there must be a duty to treat, and therefore criticisms of the arguments offered for the duty must be mistaken. This sort of reaction obviously begs the question in assuming regardless of argument that there must be a duty to treat. But the more interesting mistake is assuming that the only thing that could be wrong is the violation of a duty. There are other terms for expressing moral criticism of at least some such behaviour, but a duty-obsessed monomania blinds us to them. Even in the absence of a clear duty, there may still be something ethically troubling in decisions by professionals deliberately to avoid caring for patients who place them at some risk of contagion.
When it is still troubling, it is because of a failure of professional virtue, not a failure of duty.

SPEAKING ALSO OF VIRTUES
If we can’t say that caring for these patients is a basic duty shared by all professionals, it doesn’t mean we can say nothing. For, once we’ve set the language of duty to one side, we can say something different: that the willingness to care for risky patients is a very good and selfless thing, which exemplifies the highest ideals of the profession. Those who are willing express a virtue of professional character that all physicians should strive for but that not all will achieve.

Rights, obligations and duties are not the only sorts of moral considerations that move people to act. As Aristotle noted, we also strive for excellences of all kinds, including the moral virtues, which require more than the application of a rule or performance of a particular action on each occasion. It is a fallacy, then, to assume that the only alternative to a regime enforcing the duty to treat is a wholly self-interested “volunteerism”, sure to result in a shortage of physicians willing to treat risky patients—for example, see Huber and Wynia. Physicians can be drawn to ideals even when they’re not driven by duties. Virtues and ideals can motivate caring for risky patients, and their language also offers a different vocabulary for understanding the ethical dimensions of caring for, or avoiding, patients with a deadly disease.

Admiring heroism
First, we can admire and praise those who put themselves at risk for patients. It’s not for nothing that one article discussing the experience of health professionals caring for patients with SARS in Taiwan was titled “Heroes of SARS”. Indeed, there were many heroes who selflessly devoted themselves to caring for these patients despite the risks, known and unknown.

Their heroism cannot be fully understood as the performance of a duty. We appreciate the modesty of a hero who says, “I was only doing my duty,” because we know he was doing something more admirable than that. A duty sets a minimal standard of conduct, and as such its performance deserves no special praise. If there were really nothing at work but the common professional duty to treat risky patients, then the language of heroism would be out of place. As Onora O’Neill remarks in her discussion of supererogation, here “the ordinary measures of duty” have been exceeded, even if what has been done is a type of action that under other circumstances would be nothing but a duty.

There’s another reason why our admiration for these providers can’t be explained by their performance of a duty. One can do what duty demands, but for less than admirable reasons. Those who provided care under threat of losing their jobs, as happened to nurses at Toronto’s Mount Sinai Hospital, performed as duty presumably required, but the performance is not an admirable one when the motive is not—similarly, perhaps, for the physicians and nurses in Taiwan who were given per diem bonuses for providing care to patients with SARS. Even when we praise those who have done their plain duty, we intend to praise the persons, not just the performance. Discussing the situation of persons who discharge their duty to visit a sick friend but do it grudgingly or resentfully, Marcia Bloom says such cases illustrate that there is “something wrong with acting from a false conception of one’s duty, [when] it overlooks the importance of the attitudes and dispositions one has when one performs certain acts, especially those which are intended to express affection or concern” (p205).

The agent’s motives and character are even more central to our response to supererogatory acts that lie beyond duty. Their point, Heyd remarks, “lies … in the good will of the agent, in his altruistic intention, in his choice to exercise generosity or to show forgiveness, to sacrifice himself or to do a little uncalled favor, rather than [just] strictly adhering to his duty.” When those who provided care to patients with SARS deserved to be called heroes, it was because of who they were, as much as what they did.

Recognising the importance of motives
For the same sort of reason, motives play a central role in how we should respond to refusals to care for risky patients. Those who refuse out of an overwhelming fear for themselves, or fear for the safety of their families, should be judged differently from those who refuse because they have no aspirations to altruism or benevolence, and so have no sense of regret or moral loss when they act solely out of self-interest. Such persons can live by the rules, performing as duty demands, but are defective in their professional character. It’s not just that they are not to be trusted when there’s no one watching. Even when they follow their fiduciary obligations to their patients (for example, by avoiding financial inducements that may conflict with their patients’ interests), their actions have lost all but their narrowly utilitarian moral character.

Accommodating struggle
First, we can recognise and accommodate the inevitability of struggle towards an ideal. The ability to consciously and willingly put one’s welfare—indeed, one’s life—after the needs of others may be a trait of character towards which health professionals should aspire, but it is not easy to do, and is not easily made routine or commanded by sanction. Fear for one’s life is a powerful emotion. The ability to overcome it varies considerably from person to person, and in the same person from occasion to occasion. Few of us have perfect mastery over
our fear, and those who do master their fear are often impulsively reckless, rather than courageous, to borrow another Aristotelian point. The duty to treat cannot accommodate the difficulty in living up to this ideal, since the imposition of a duty assumes that acting on it is within the capacity of every moral agent bound by it. As Urmson notes, duties must be within the reach of ordinary people, or else we breed contempt for or despair at their demands.25

Both struggle and failure are compatible with full possession of virtues and aspirations. The possession of a virtue or an aspiration does not require its achievement or enactment on every occasion. Virtues are dispositions revealed in patterns of behaviour over time. I can’t judge whether a person is courageous from a single performance, but only whether the performance was. Similarly, physicians who avoid caring for a risky patient but who in their other behaviour reveal their altruistic nature should not be judged to lack this virtue. What is more, their otherwise virtuous behaviour provides the evidence that their motives on this occasion are probably not unworthy ones. By the same token, physicians whose avoidance of risky patients is wholly in keeping with the attitudes that their other behaviour reveals leave us with little confidence in their motives.

I should note that it is occasional failure that is compatible with possession of the virtue or the aspiration. We don’t believe people who profess their aspiration to altruism but never act on it when the occasion arises.

Avoiding condemnation in favor of encouragement

Second, once we acknowledge the aspirational quality of this ideal, we can sympathetically understand that there will be some health professionals—perhaps sometimes many, perhaps even ourselves—who will fall short, not being able to master their fear, for themselves and for their families. And we will appreciate that even good people will have this virtue to varying degrees, in varying circumstances. We will be reluctant, then, to condemn or punish those who are overcome by their fear on particular occasions but whose behaviour otherwise suggests their allegiance to the ideal. This stands in contrast to our response to someone’s failure to perform a duty, where what is usually called for is moral disapproval, often accompanied by sanctions.

But we will avoid using sanctions to encourage professionals towards this ideal, because the relevant motivation must be internal rather than external in nature. As already noted, those who act from fear of punishment or anticipation of reward may perform as they should but lack the professional virtue that makes their decision morally admirable. Psychological research has clearly shown that threat of disapproval or punishment for failure to perform often reduces people’s intrinsic motivation, since it signals a lack of trust in their capacity or goodwill. Providing rewards, particularly significant ones, can have a similar effect, although for different reasons.24

If we want to strengthen the ideal of altruism in health professionals and their willingness to take risks for the sake of patients, we should make use of what is known about motivating altruism and empathy. People display greater altruism when they’re given models of altruistic behaviour (p42),25 and so we would be well advised to make publicly celebrate the heroes who have exemplified that virtue. We will personalise requests for help, asking individual providers directly, and emphasising the unique skills that only they can bring to the task (p35).24 We will personalise the patients, as well, to evoke sympathetic appreciation of their need for help. These and other techniques that encourage us to take the other’s perspective arouse the sympathetic feelings that lead us to altruistic behaviour.26

Matthew Lukwiya, the heroic physician who died of Ebola after rallying the staff of St Mary’s Hospital in Uganda to remain at their posts, understood what was needed to inspire others. After many deaths among healthcare workers, when the nurses of St Mary’s were threatening to leave en masse, Lukwiya at first admonished them for not performing their duty, telling them the patients’ deaths would be on their heads. The accusation changed few hearts. They were called to their ideals only when Lukwiya offered himself as the model, telling them they could leave if they wanted, but that he would stay, even if he was the only one.27

CONCLUSIONS

There is, then, no basic duty to take chances in the care of risky patients that can confidently be applied to infectious diseases carrying out-of-the-ordinary risks for providers. This does not mean that decisions not to care for such patients are beyond moral criticism. Particular decisions might violate other duties, to patients or to colleagues. Or they might be badly motivated, revealing the lack of any altruistic ideals. But to effectively urge professionals towards such ideals, and to fully understand the moral character of decisions whether to provide care in the face of danger, we should prefer the language of moral celebration over the language of moral censure.

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REFERENCES


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