

threatened disciplinary action or orders by government to conscript essential workers. However, while this is a key factor to address a shortage of HCPs during a pandemic, it will be insufficient to meet the needs of the healthcare system.

As a result, we would stress that it is imperative to put our eggs in more than one basket in this planning stage. Plans that are too narrowly focused will be inadequate. It will also leave governments, professional bodies, and decision-makers open to the criticism that other reasonable means of addressing anticipated problems were not pursued. The approach must be multi-faceted. All means of attempting to ameliorate the shortage of HCPs to provide care should be considered.

This does include, among other things, the pursuit of clear statements within professional codes of ethics, both as written by associations and as adopted by regulatory bodies, that a duty to treat is owed in times of emergency not only to patients within established relationships with HCPs, but to potential patients who will be left untreated if HCPs fail to step up to offer services that only they can provide. As with the allocation of scarce resources during such times, a shift from clinical to public health ethics will be necessary and supportable.

To support such work amongst such professional bodies, we would argue against Malm and colleagues (2008) caution to hold off on the pursuit of ethical justifications for a duty to treat. We would exhort that while we should not run headlong into traffic, we do need to hurry (after looking both ways) to facilitate the creation of clear and detailed statements of such a duty, or the lack thereof. A stand must be taken and then debated; it must be justified or toppled. This must be done not only within the confines of the health professions, academia and pandemic planning, but should involve wide public consultation as well. For it is vital to know where we stand on this issue as a society, both to plan for a future pandemic, but also to assess the society in which

we are living. Will we discover it is based on the values of the common good? Or the preservation of autonomy in times of crisis, possibly at the expense of our neighbors? Either way, it is a discussion that must be carried on. To remain silent is, indeed, an unethical option for those that would call themselves members of a profession. ■

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The Duty to Care in a Pandemic

Joint Centre for Bioethics Pandemic Ethics Working Group

Malm and colleagues (2008) consider (and reject) five arguments putatively justifying the idea that healthcare workers (HCWs) have a duty to treat (DTT) during a pandemic. We

do not have sufficient space to examine their rejection of each of the five arguments in any detail. Instead we argue that the relevant focus for debate should not be on DTT but

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rather on a duty to care (DTC); that the account of obligation that they use is inappropriate in a number of respects; and that HCWs and the public, rightly, see a broader conception of obligation at work in relation to the DTC.

THE RELEVANT OBLIGATION: DUTY TO CARE

In our view focusing on DTT inappropriately narrows the discourse of pandemic preparedness in two respects. First, it focuses only on issues relating to *treatment* and second it focuses on the actions of *individuals*. We suggest that it makes more sense to focus on the idea of an obligation (duty) to care (DTC) not a DTT for the following reasons.

First, the DTC is not merely an obligation to treat patients with an infectious disease. It comprises a requirement to pursue a variety of ends to mitigate the negative effects of a pandemic. This may involve HCWs fulfilling duties 'on the front line' of the pandemic, but may also extend towards providing less risky clinical duties or essential non-clinical assistance (e.g. managing, planning, communicating with the public etc). Although some HCWs may indeed be exposed to quite onerous and risky working conditions, it is misleading to suggest that such extreme conditions will be typical. Such risks may be relevant to assessing the limits of the DTC, but specifying the obligation in these terms invites too narrow a conception of the relevant obligation.

Second, the DTC is an obligation that ought to be viewed as binding others, not just HCWs. Government officials and members of healthcare institutions have a DTC that requires that they provide for the health and safety of HCWs and for the care of those who fall ill on duty. This will include provisions such as ensuring adequate training, protective and supporting measures that will allow HCWs the best chances at preventing infection; sufficient professional indemnity and personal insurance coverage for life and disability to cover HCWs who become sick or die as they place themselves in harm's way; mitigating conflicts between personal and professional demands. The DTC does not merely extend to those with specialist training or professional obligations. It is important to consider all relevant occupational groups (e.g., porters, cleaners, hospital cooks, morticians) (University of Toronto Joint Centre for Bioethics Pandemic Influenza Working Group 2005). Members of the public can also be understood to be bound by some version of this obligation, in that they ought to take steps to prevent their own infection or if infected comply with therapeutic requirements, using overburdened healthcare services responsibly, for example.

THE ORIGINS AND SCOPE OF OBLIGATIONS

Malm and colleagues (2008) seem to have a very narrow conception of obligations. First, they conceive of DTT as coming into existence only as a result of consensual acceptance by the relevant professional bound by the obligation. It is not clear why we have to accept this as the only way we can be bound by such an obligation; certainly they provide no justification for this voluntarist account of obligations. By contrast, it seems to us that, many obligations are just

part of what it means to exist within the context of certain relationships with others.

Second, they seem to assume that the relevant duty will be unconditional in nature. However, while obligations provide forceful normative requirements to act, they need not be absolute in nature and if a particular obligation is seen as generally taking priority over others this needs argumentative support (Dawson and Garrard 2006). Within moral theory and from experience of everyday life, we know that obligations can be overridden. The fact that a DTC can be outweighed by other considerations is no reason to conclude there is no demanding DTC in existence.

Third, their focus on DTT in isolation is misconceived. When we consider our obligations, part of what is necessary, is to consider how different obligations may come into conflict with each other and how such conflicts should be resolved. For example, there are a number of other obligations at play in the context of a public health emergency, such as an influenza pandemic. In addition to normative conflicts between moral and prudential considerations, there will likely be conflicts between different moral obligations. Take, for example, a conflict that might exist for a HCW between a personal moral obligation (e.g., providing care to one's family) and an impersonal moral obligation (e.g., providing care for infected patients). In such a situation, complying with the DTC is not simply a matter of choosing to fulfill one's professional role over one's role as a parent. The obligations need to be weighed against each other, and if fulfilling both is impossible, then a decision will have to be made about which takes priority. The actual extent to which a HCW has to endure serious inconveniences (e.g., longer hours away from family, assignments outside one's normal area of practice), barriers to being able to provide adequate levels of care (e.g., asked to perform duties outside of one's competence, exhaustion), risk of serious harms (e.g., infection, quarantine, emotional distress, death) and competing normative demands (e.g., taking care of sick family members) will all have to be relevant considerations in determining what exactly can be fairly demanded under the DTC and under what conditions the obligation is defeasible.

By contrast, the model that lies behind Malm and colleagues (2008) approach is one where DTT continues to exist until the level of risk of harm becomes too great. We are owed an argument justifying the maximum level of risk appropriate before the obligation is extinguished. Moreover, action or its correlate inaction in light of a putative duty will itself carry with it a degree of risk that will have to be taken into account. In another regard, their argument against an absolute duty does not show there is no DTC, as it is quite plausible that there is a *prima facie* DTC.

A BROADER DUTY TO CARE

As the preceding section has indicated, the issues relating to DTC are nuanced and complex. This richer idea of obligation is supported by an empirical study conducted among HCWs and members of the public in Toronto following SARS. It was

found that most members of these groups held the DTC to be something that ought to be placed within a broader social context (Bensimon et al. 2007). Many of the participants argued that the DTC was relevant at both the level of the individual HCW *and* of society. This suggests that DTC should not be left to personal choice or viewed as a matter of voluntary service.

The kind of individualized sense of duty outlined by Malm and colleagues (2008) becomes problematic when we look at the scope of obligations that factor into the decision-making process. Personal or voluntary choice, while it emerged as a relevant consideration, is but one component defining the scope of obligation. In essence, healthcare providers do not make the decision to fulfill the DTC in isolation from their personal, familial, community, institutional, and societal context. But more than that, they *cannot* fulfill this duty without the support of this broader context.

Indeed, one of the most pervasive findings of the study points to the importance of reciprocity in the context of healthcare institutions (meso) and of society more generally (macro). But here reciprocity is not simply a matter of a simple social contract between patient and HCWs, but rather as a covenant between HCWs and society at large. The view that reciprocity is a matter of a social contract is both inadequate and insufficient as it, once again, emphasizes a narrow and individualized notion of obligation. Of course, we need to be careful not to infer directly from these empirical observations to what we ought to do. The empirical findings do remind us that social context, the perceptions and beliefs of (HCWs) and members of the public are non-ignorable considerations in pandemic planning. Engagement of society on issues of DTC in a pandemic or similar emergency is thus an important dimension, and one that Malm and colleagues (2008) do not fully consider. Given the fact that the

relevant conception of the DTC is at least partly constituted by what society expects from HCWs and others, such empirical findings are directly relevant to the determination of our obligations.

CONCLUSIONS

We have argued that Malm and colleagues (2008) conception of the relevant duty is too narrow, and that our focus should be on the DTC not the DTT. We have also argued that their general background account of obligations is too limited in a number of respects, and that we need a sense of obligation grounded in real social relationships. Contrary to what Malm and colleagues claim, the DTC is a core obligation, not just for HCWs, but also for us all. ■

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Without Consent: Moral Imperatives, Special Abilities, and the Duty to Treat

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In “Ethics, Pandemics, and the Duty to Treat,” Heidi Malm and colleagues (2008) present a much-needed evaluation of some of the more promising defenses of a special moral duty to provide medical care during emergencies. However, Malm and colleagues err in limiting their discussion to consent-based variants that provide only a narrow justifica-

tion for this duty. If healthcare professionals do indeed have a moral duty to risk harm to themselves by treating patients during public health emergencies, the sort of duty we envision seems closer in kind to a moral imperative—one that is owed *a priori* and cannot be dismissed merely by, in Malm and colleagues’ words, “signaling dissent” (2008, 4). Taking

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