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Editorial

Are you coming to work during pandemic flu?

When pandemic flu comes, it is predicted that the demand for ventilator support in England will exceed 200% of present intensive care capacity [1]. Cancelling elective surgery will increase capacity [2] but more importantly will release theatre ventilators for use. Anaesthetists, and not just anaesthetist/intensivists, will be pivotal to the management of this increased capacity. Although the need for anaesthetists during the pandemic is clear, the personal risks which anaesthetists will assume will be far in excess of normal. This editorial seeks to explore the moral obligation anaesthetists have to come to work during pandemic flu.

An obituary and challenge

Dr Joanna Tse Yuen-man, a 35 year-old respiratory physician, was the first public hospital doctor to die from Severe Acute Respiratory Syndrome (SARS) during the 2003 Hong Kong epidemic [3]. Her death generated great outpouring of public emotion in Hong Kong. Two quotes highlight sentiments regarding her sacrifice, '...as a doctor her duty was to save lives', [4] and, '...the dedication and professionalism of the front line medical personnel went far beyond the simple duties of a "job"' [5].

An uneasy balance exists between the duty to save lives and the extent which this duty imposes upon us to risk our lives to satisfy this duty. Do we as medical professionals have moral obligations to our patients and society that must be met, even at risk to our own lives? I believe there are three strong arguments that can be made to support the view that such an obligation does exist: the oaths we may have taken, the privileges we enjoy and the special skills we hold [6–10].

Oaths and codes of conduct

The origin of the word professional comes in the public profession of one's religious faith and this can be contrasted to private religious confession [11]. There is an old sense, that to be a professional is to stand publicly for something. Do we as doctors publicly stand for something?

The familiar document *Good Medical Practice* begins [12]:

> The Duties of a doctor registered with the General Medical Council. Patients must be able to trust doctors with their lives and health. To justify that trust you must show respect for human life and you must:
> - Make the care of your patient your first concern
> - Protect and promote the health of patients *and the public*. [my italics]

The medical profession is so steeped in the tradition of public profession that some medical students take the 2000-year-old Hippocratic Oath. The modern World Health Organization Declaration of Geneva has the more general: 'I solemnly pledge myself to consecrate my life to the service of humanity' [13]. Whether or not an individual doctor ever took these oaths has little moral impact, since the general public believes that doctors have taken oaths and the medical profession has never tried to convince the public otherwise.

More specific to pandemics, the 1847 American Medical Association Code of Ethics states, '...and when pestilence prevails, it is their duty to face the danger, and to continue their labours for the alleviation of the suffering, even at the jeopardy of their own lives' [14]. The General Medical Council allows us to get off lightly in comparison, stating only that, 'In an emergency, wherever it arises, you must offer assistance, taking account of your own safety, your competence, and the availability of other options for care…' [12].

Nevertheless, doctors continue to publicly profess a societal duty to treat sick patients and patients die of diseases that are contagious and infectious; even to doctors. This puts doctors in a special category because not all jobs carry such a duty or risk. Policemen and soldiers are similar and like doctors take oaths of service; hairdressers and plumbers do not.

Privileges lead to obligations

Cynically, it might be considered that oaths and Codes of Conduct are exercises in public relations but the public can surely have no right to expect doctors to risk their lives for them. Doctors do not practice medicine by right but by privilege; and that privilege is conferred by society onto doctors [7]. Textbooks have been written about rights but suffice it to say that a right is something you can demand of others; being in receipt of a privilege means that something can be demanded of you.

The following are some of the privileges doctors enjoy. Doctors self-regulate and self-certify through the General Medical Council and the Royal Colleges. Yes, our professional autonomy and monopoly is under threat but it is important that perceived threats are not channelled into a belief that we are not privileged or that society no longer values us. In British surveys, doctors are consistently rated as the most trusted profession [15].

Doctors are still very well paid and of those professions who are called upon to risk their lives for the public, we are paid the most money for the least risk. Not only is our salary high but it is estimated that society contributed £200 000 to each of us during our medical school training [16]. Additionally many patients allowed us to examine them as part of our medical student training. Since we never paid them a fee for this service, and our company was probably less scintillating then we

remember, it was likely that these many patients permitted our examination for a socially positive moral goal: to make us better doctors so that one day in the future we would use our knowledge to benefit others. If the reason for such assistance was this, then to accept entails accepting an obligation.

Society in an emergency such as pandemic flu has a right to call on that financial and moral investment. We should not forget that, during the SARS epidemic, the majority of the health care professionals who lost their lives were not doctors, and yet these other health professionals do not enjoy the same privileges which society grants to doctors.

Special skills increase our burden of duty

The *Canadian Journal of Anaesthesia* in 2003 reported the following: 'In the second month of the outbreak, a cluster of six health care workers contracted SARS after participating in a difficult and prolonged tracheal intubation. Since then, most hospitals have included anesthesiologists, the specialists in airway management, to assist in the tracheal intubation of SARS patients (p. 993)' [17]. Apparently in this case the intubating doctor was not an anaesthetist: why ever not? Who has the best chance of getting the tracheal tube in quickly with the least chance of spreading the infection to others, all during an incredibly stressful situation whilst wearing unfamiliar personal protective equipment? Or should anaesthetists suggest that a few emergency medicine doctors, along with a few respiratory and infectious disease physicians, have a bit of practice on a SARS Intubating Dummy and then do it for real in our place? Having special skills places an extra duty upon us [9] to come to work during pandemic flu.

If you have not been trained to use the personal protective equipment, does this reduce your moral obligation to help? Yes, if the anaesthetist standing next to you has been trained. However, in a more general context your skills in dealing with the critically ill outweigh your lack of skill with protective equipment.

I find it difficult to escape the conclusion that there is a moral obligation on anaesthetists to come to work during pandemic flu. However in 2003 a working group headed by the ethicist Peter Singer was unable to establish consensus regarding the *extent* to which healthcare workers are obligated to risk their lives in delivering clinical care [18]. The legitimate arguments that may limit our obligation include: the duty to help is corporate not individual, heroes are volunteers, there are conflicting other obligations in our lives, and there is a social contract between society and doctors that runs two ways [9, 10, 19–21].

The duty to help is corporate

It is possible to argue that our moral obligation to society is corporate, not individual [19]. Provided that an anaesthetist attends the flu patients, and provided that there is no shortage of these volunteers, then our individual obligation is discharged.

Certainly once the true nature of SARS was known, health care workers in Hong Kong, Singapore and Toronto were all volunteers. This argument has two important caveats. The opportunity to help occurs at a specific time and place [9]. It may not be possible when faced with a flu patient requiring intubation for you to go home in the hope that some other colleague will volunteer in your stead. The argument also leads to the morally repugnant conclusion that the profession should simply hire developing world anaesthetists to act in our place.

Heroes are volunteers

Daniel Sokol, an ethicist who has written on this topic, illustrates the difference between duty and heroism with the following example:

If a swimmer in an isolated but supervised beach starts to drown 50 m from the shore, the lifeguard may reasonably be expected to attempt a rescue. This, after all, is the lifeguard's duty as a qualified professional. If, however, the person is drowning 2 miles out and is surrounded by a school of hungry, man-eating sharks, then one cannot expect the solitary lifeguard to dive among the sharks to save the swimmer, even if that means the swimmer will certainly die and even if the lifeguard has a small chance of saving him or her (at great personal risk) (p. 1240) [20].

The equivalent for an anaesthetist during pandemic flu might be entering, whilst not wearing any personal protective equipment, a ward full of coughing flu patients to intubate a deteriorating patient with haemoptysis. Even on the battlefield, suicide missions remain voluntary.

At some point during the treatment of a patient, the risk to an individual doctor might cross a line and move from duty into heroism. During the emergence of HIV in the 1980s a small number of vocal doctors shamefully professed that this line be drawn very close to no risk at all. It is to the credit of anaesthetists like the recently deceased Professor Sam Hughes of the University of California San Francisco, who took a public stand against such hysteria, that such attitudes were changed [22].

We have other obligations in our lives

Although the duty to risk our lives does exist, we also have other obligations, to those other patients who are sick but not from flu and to our family; these obligations compel us to stay alive and to stay healthy. None of us work in a vacuum and, during a pandemic, our thoughts will be focused as much on the risk to our families as to our patients [23]. Who will look after our children when nurseries and schools are closed, what if both parents are doctors, and who would wish to return home after a shift on the flu wards? Heroism seems less admirable and more foolhardy when these other obligations are considered.

The social contract between society and doctors

Society has a duty to continue to support doctors during a pandemic both in terms of resources to do the job and in terms of physical, psychological and financial support [10]. This will be a great challenge to this country, which has historically under-funded its health services. We work, however, within the context of our society. An African

doctor cannot refuse to treat patients with HIV unless given the same resources as a western doctor. Likewise we must continue to work within the constraints of our system.

Conclusion

Unless the fabric of society itself is threatened or unless doctors fail to meet their perceived corporate obligation, it remains almost certain that coming to work during pandemic flu will be voluntary and unenforceable. So when pandemic flu does come and you are faced with this decision, you must know that the ethical pendulum is not starting at equipoise. If you do not have a stronger, more compelling reason, then there remains an obligation on us as anaesthetists to risk our lives and come to work.

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References

1 Menon DK, Taylor BL, Ridley SA; Intensive Care Society, UK. Modelling the impact of an influenza pandemic on critical care services in England. *Anaesthesia* 2005; **60**(10): 952–4.
2 http://www.dh.gov.uk/en/Publichealth/Flu/PandemicFlu/FAQonly/DH_065088 (accessed 18 February 2008).
3 http://english.peopledaily.com.cn/200305/23/eng20030523_117091.shtml (accessed 23 March 2008).
4 http://www.joannatse.com/esite/index.php (accessed 21 October 2007).
5 http://www.cpu.gov.hk/tc/documents/conference/20030704opening_e.rtf (accessed 03 March 2008).
6 Camenish P. On being a professional, morally speaking. In: Baumrin R, Freedman B, eds. *Moral Responsibility and the Professions*. New York: Haven Publications, 1983: 42–61.
7 Bayles MD. *Problems of Professions. Professional Ethics*. Belmont: Wadsworth, 1989: 7–15.
8 Silver M. The morality of refusing to treat HIV-positive patients. *Journal of Applied Philosophy* 1989; **6**(2): 149–57.
9 Clark CC. In Harm's way: AMA physicians and the duty to treat. *Journal of Medicine and Philosophy* 2005; **30**(1): 65–87.
10 Upshur R. *The Role and Obligations of Health-care Workers during an Outbreak of Pandemic Influenza*. http://www.who.int/ethics/PI_Ethics_draft_paper_WG3_14Sept06.pdf (accessed 26 June 2008).
11 Centre for Human Bioethics Monash University. *Professional Autonomy. Ethical Issue in Patient Care – Unit Book 3*, Monash University, Victoria, Australia, 1996.
12 General Medical Council. *Good Medical Practice* 2006. http://www.gmc-uk.org/guidance/good_medical_practice/GMC_GMP.pdf (accessed 26 June 2008).
13 http://www.wma.net/e/policy/c8.htm (accessed 22 April 2008).
14 American Medical Association. *Code of Medical Ethics of the American Medical Association* 1847: p. 105. http://www.ama-assn.org/ama/pub/category/2498.html (accessed 26 June 2008).
15 http://www.ipsos-mori.com/trust/truth.shtml (accessed 23 March 2008).
16 http://student.bmj.com/issues/00/02/life/34.php (accessed 24 March 2008).
17 Peng PWH, Wong DT, Bevan D, et al. Infection control and anesthesia: lessons learned from the Toronto SARS outbreak. *Canadian Journal of Anesthesia* 2003; **50**(10): 989–97.
18 Singer P, Benatar SR, Bernstein M, et al. Ethics and SARS: lessons from Toronto. *BMJ* 2003; **327**: 1342–4.
19 Tomlinson T. Counterpoint – caring for high-risk patients: a duty or a virtue? *Medical Humanities Report* 2003; **25**(1): http://www.bioethics.msu.edu/mhr/03f/sars.html (accessed 22 October 2007).
20 Sokol D. Virulent epidemics and scope of healthcare workers' duty of care. *Emerging Infectious Diseases* 2006; **12**(8): 1238–41.
21 Lawson AD. An alternative view: pandemic 'flu and intensive care – an ethical minefield. *Journal of the Intensive Care Society* 2008; **9**(1): 13–5.
22 Rosen M. Remembering Sam Hughes. *International Journal of Obstetric Anesthesia* 2008; **17**: 101–2.
23 Maunder R, Hunter J, Vincent L, et al. The immediate psychological and occupational impact of the 2003 SARS outbreak in a teaching hospital. *Canadian Medical Association Journal* 2003; **168**(10): 1245–51.