ETHICS MAN **Daniel K Sokol**

When can doctors stay away?

Many frontline clinicians haven't been consulted over their duty of care should a flu epidemic occur

Ebola haemorrhagic fever is an acute viral disease with a mortality ranging from 25% to 90%. First reported in 1976, the disease continues to claim victims in Africa, most recently in January in the Democratic Republic of Congo. No cure or vaccine exists. When I studied the history of the disease in 2001 I was surprised to find that, time and time again, healthcare workers fled the scene of epidemics, leaving dying patients behind. I was then a historian rather than an ethicist and did not dwell on the morality of this practice.

In July 2003 I visited Mount Sinai Hospital in Toronto, Canada, at a time when people were still dying from severe acute respiratory syndrome (SARS). The fear was palpable. On the corridor walls, posters praised the work of the hospital's "heroes." Some clinicians, however, did not show up for work, and colleagues accused the absentees of failing to discharge their "duty of care." On that same trip, my mentor, Kerry Bowman, recounted a recent consultation. An 82 year old nurse with advanced liver cancer had requested an urgent ethics consultation. In 1942 she was working in a military hospital in Malaysia when, with the impending arrival of the Japanese imperial army, all staff and patients were ordered to evacuate the premises. Because of illness or injury, 126 patients were unable to walk. Left behind, they would be killed or imprisoned by the invading army. The retired nurse, 60 years on, still wondered whether she was right to abandon those patients.

I developed an interest in clinicians' duty of care, in particular the limits of the duty. Just as lifeguards have no duty to dive into shark infested waters to save a drowning swimmer, it seemed obvious that clinicians also have limits to their duty of care. This is at odds with the guidance of the General Medical Council in *Good Medical Practice*, which states: "Doctors must not refuse to treat patients because their medical condition may put the doctor at risk." The issue is topical. Clinicians in the United Kingdom and abroad may well experience a pandemic of bird flu in the near future. Even if only moderate in virulence, an epidemic could lead to 865 000 hospital admissions and 200 000 deaths in the United States. In the UK the estimates vary between 50 000 and 750 000 deaths, depending on virulence.

Establishing the boundaries of the duty of care is complex. They depend on the clinician's specialty, the terms of the employment contract, the likely benefits to the patient of the treatment, the risk to the clinician, and the moral weight of the clinician's other duties. As well as duties to current patients, doctors can have obligations to future patients, themselves, their family, their colleagues, their community, and society. These duties may clash in emergency situations, and it is not clear why a doctor's duty to patients should trump a duty to loved ones, for example. Furthermore, at what level of risk does the duty fade away? Should a doctor come to work with a 10% risk of death—or even a 1% risk? What corresponding benefit to patients is required to justify that 1% risk of death? Along with physical dangers, there are psychological burdens. During the SARS outbreaks in Toronto, between 29% and 35% of hospital workers experienced a high degree of distress, particularly workers with children. Perceived as a source of infection, hospital workers and their families may be ostracised by the community. They may feel shunned and isolated. Although the academic literature on clinicians' duty of care is growing, the duty of care of non-clinical personnel, such as porters, cleaning staff, and mortuary workers, is relatively unexplored.

The UK Department of Health's Committee on the Ethical Aspects of Pandemic Influenza has drafted a framework for policy and planning. The framework stresses the importance of openness, transparency, and inclusiveness: "Those making decisions will involve people to the greatest extent possible in aspects of planning that affect them." The health department's current human resources guidance for the NHS states: "Employees will have no right to refuse to attend work during a pandemic, unless there is a clear health and safety risk. The employment contracts of staff will oblige them to treat patients." Yet how many frontline clinicians have been consulted over their duty of care in a pandemic situation? A failure to engage with the vast majority of clinicians in this debate may lead to avoidably high rates of absenteeism and jeopardise the rest of the pandemic plan. What should be included in the employment contracts? How much flexibility should there be?

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Time is of the essence. The debate can hardly occur once the epidemic has started, nor should the discussion on the duty of care be restricted to academics and pandemic planners. It should extend to those whose duty will be challenged. It is a mistake to assume that hospital workers are familiar with relevant guidelines or even the terms in their employment contract. Without an awareness of the matter, they cannot give valid consent to fulfil their duty of care in a pandemic situation. Individual trusts and hospitals must not shy away from addressing the issue with staff. Like many medical procedures, it will be an unpleasant but necessary process.

Daniel K Sokol is lecturer in medical ethics and law, St George's, University of London
daniel.sokol@talk21.com

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References are in the version on bmj.com
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