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VIEWS AND REVIEWS

# Duty to treat: where do the limits lie?

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Doctors are dying. The combination of a novel virus, no existing treatment, and inadequate supplies of personal protective equipment (PPE) is putting frontline health workers at risk of serious harm. The question arises: when does work based risk become unacceptable? Does a point come when health professionals have the right not to treat seriously ill patients if their PPE is inadequate?

Doctors' primary duty—to quote the General Medical Council—is to make the care of patients their first concern. This is a paradigm example of what moral philosophers call a "special" positive duty. It can be helpful to compare them to general positive duties. It is widely accepted that we are all under general positive duties—positive in the sense that they require some action from us. If I see a toddler struggling in a garden pool, and I can rescue her without excessive risk, then I am under a duty to do so. It would also be reasonable to criticise me for refusing. These duties are general as they presuppose no special relationship between rescuer and rescued. General duties are not onerous. If I cannot swim and see a child struggling in a torrent, it is not clear that I have a duty to rescue her. If I were to try, this would be an example of supererogation: an act above and beyond the call of duty.

The obligation to which the GMC refers is specific; it rests on a special kind of relationship between, if you will, rescuer and rescued, between doctor and patient. It is widely regarded as stronger than a general duty. It is a duty chosen by those who seek to join the profession. It is a duty to treat the sick irrespective of the origins of their sickness. Broadly speaking, doctors sign up both contractually and morally to do so. The labours of Dr Rieux in Camus's *La Peste* are exemplary. If I turn up at a burning house at the same time as an on-duty fireman, his duties of rescue are surely stronger than mine. Not only has he contracted to undertake the risks of his profession—and therefore in some sense consented to them—he is also properly trained and equipped.

But are there limits to this duty? How much risk is too much risk? It is probably fair to say that, at least in resource rich settings, medicine has become a low risk profession. Gone are the days—or so we thought—of plague doctors. The apparent triumph over infectious diseases in the 20th century pushed such heroism into the medieval past. It seems a stretch to say that, in entering medicine, doctors today consent to self-sacrifice. Surely what is said of a soldier cannot plausibly be said of a doctor—that she accepts she will likely be called upon to put her life on the line.

As with many principle-like statements, the obligation to make patient care your first concern requires interpretation. It is, straightforwardly, not a doctor's only duty. The failure of employers and the government to supply effective PPE throws a spotlight on doctors' duties to take care of themselves. These are more than self-referring duties. Doctors are critical to the covid response: if they sicken, so the response is weakened; if they unknowingly become infected, they can infect patients and colleagues. Doctors also have obligations to those close to them: to parents, spouses, partners, children. The primary duty to this patient, here and now, is one part of a web of obligations.

Lack of PPE also generates problems with separate, but obviously related, duties: an employer's duty of care to employees—and duty to patients infected by health workers—with all their supporting legal scaffolding. It also engages the principle of reciprocity. When people put themselves in harm's way in pursuit of the public good, they acquire corresponding entitlements—to protection yes, but also to certain benefits, such as the best available healthcare, to financial support should they become ill, and to life insurance should they die. We get no sense that doctors would be unwilling to work if PPE were adequate. It is the failure of those tasked with supplying PPE that has thrust them into this dilemma.

So how do we make sense of these entangled obligations? In the absence of proper PPE, moral and legal obligations to protect staff and patients at potential risk of infection, along with duties of reciprocity, are unfulfilled. Doctors are forced to look to obligations of self-care, to the duties they owe those close to them—and to patients they might unwittingly infect. As such, the duty to treat weakens. The contract, what could be called doctors' agreement to treat, both explicit and implied, legal and ethical, is breached. Without proper equipment it seems to us that doctors cannot be duty bound to expose themselves to potentially mortal risk.

Many doctors, despite agonising over the deep ethical ramifications of these decisions, will of course continue to provide treatment. And when the risks are not excessive, perhaps it is reasonable to encourage them to do so. But these actions are supererogatory—they lie beyond the normal requirements of duty. Doctors cannot be compelled to provide treatment or

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be criticised or penalised for turning away. And those who choose to treat should be applauded—and properly rewarded—for doing so. Better by far though to invest in a health system that offers appropriate protection, so moral heroism is not required.

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