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 in-
cluded 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 anesthe-
tist: why ever not? Who has the best
chance of getting the tracheal tube in
quickly with the least chance of spread-
ing the infection to others, all during an
incredibly stressful situation whilst
wearing unfamiliar personal protective
equipment? Or should anesthesiasts
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 anesthetist 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 equip-
ment.

I find it difficult to escape the
conclusion that there is a moral obliga-
tion 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 intu-
bation 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 writ-
ten on this topic, illustrates the differ-
ence 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 rea-
sonably 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.

D. Gardiner
Consultant Intensivist, Nottingham University Hospitals, NHS Trust, Nottingham, UK
E-mail: dalegardiner@doctors.org.uk

References
11 Centre for Human Bioethics Monash University. Professional Autonomy. Ethical Issue in Patient Care – Unit Book 3, Monash University, Victoria, Australia, 1996.
16 http://student.bmj.com/issues/00/02/life/34.php (accessed 24 March 2008).