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Pandemic and Beyond: Considerations When Personal Risk and Professional Obligations Converge.

Daniel J. Benedetti, Mithya Lewis-Newby, Joan S. Roberts, and Douglas S. Diekema. The Journal of Clinical Ethics, 2021.[1]

Short summary

In this article Benedetti et al. analyze the professional duties of health care providers and health care institutions considering the concept of risk, using the COVID-19 pandemic as an example. On basis of this analysis, the authors propose an ethical framework to guide institutional policy intended to manage risk during the current pandemic and beyond. It is suggested that this framework can be a useful too for any hospital, health agency or clinic.

Introduction

The COVID-19 pandemic has given rise to renewed debate about whether health care providers (HCP) have a duty to assume risk as they care for patients with communicable diseases. Most contributors to this debate agree there is some duty, but there is disagreement around the extent of this duty. Benedetti et al. examine the concept of risk to determine under what circumstances (if any) HCPs are justified in saying 'no' to treating a patient in need of medical care on the grounds of risk to themselves.

Key arguments:

- The magnitude of technical risks to HCPs working during the COVID-19 pandemic cannot be fully appraised, due to lack of knowledge about the virus' transmissibility and mortality rate. The magnitude of risk is also influenced by external factors, such as availability of appropriate PPE or lack thereof. Likewise, shortage of medical equipment and medications will also influence the magnitude of risk to HCPs treating patients. The probability of risk from occupational exposure also depends on the care setting, i.e. whether the HCP is providing routine care for patients or seeing patients in the emergency room. The latter has the potential for creating a higher level of exposure during emergency evaluation and situations that involve resuscitation or intubation, for example. In addition to this, some HCPs may find it counterintuitive to don adequate PPE before attending to the patient in an emergency situation. Shortage of PPE also increases the risk to HCPs. In addition to

[1] Benedetti, D.J., M. Lewis-Newby, J.S. Roberts, nd D.S. Diekema (2021).Pandemics and Beyond: Considerations when personal risk and professional obligations converge. *The Journal of Clinical Ethics,* Vol 32(1): 20-34

technical risks, the individual HCP's perception of risk must also be considered. There is variation in how HCPs perceive risks, just as in the general population. Some may be more risk averse than others and their personal social or health circumstances may influence how much risk they are willing to take.

- Scholars broadly agree that HCPs have some degree of duties/obligations to care for patients with communicable diseases based on principles embedded in the patient-care provider relationship. These principles include: expressed consent, implied consent, reciprocity and professional codes of conduct and oaths. Historically, HCP duties have been examined in relation to different infectious diseases, such as HIV, SARS, influenza and Ebola virus disease. Benedetti et al, argue that the analysis of risk in relation to these different types of transmissible diseases provides important data points for determining which level of risk HCPs can reasonably be expected to assume in general.
- Health care institutions' (HCI) obligations include the responsibility to ensure a safe work environment for its employees (including HCPs) and obligations to provide care for patients. A HCI's obligations to patients may be compromised if too many HCPs opt out of caring for patients due to concerns about risk. This may jeopardize the ability to provide care, for both patients with COVID-19 as well as for non-COVID patients.
- HCIs may choose different risk-reducing strategies to protect HCPs from harm:
    - HCIs can decide to exclude HCPs from activities that the HCI deems to be too risky. The HCIs must carefully weigh the risk of harm to HCPs to justify overriding individual autonomy. Excluding HCPs from certain high-risk activities may be justified to reduce undue influence, such as peer pressure among HCPs to continue performing such activities.
    - HCIs can also choose to accommodate individual HCP requests for alternative work arrangements to limit their risk without excluding other HCPs from performing high-risk activities. Accommodation may be justified if the individual HCP is at higher risk of complications should they contract COVID-19, for example.
    - A third strategy that HCIs can take to reduce risk to HCPs is to support the use of PPE. This approach has been widely discussed during the COVID-19 pandemic. HCIs are legally and morally obliged to provide appropriate/adequate PPE so that HCPs can fulfill their care responsibilities for patients without exposing themselves to undue risk. In this context, the obligations of the HCI also include ensuring that the PPE meets safety standards. With regards to concerns about availability of adequate PPE, the authors argue that governments and HCIs have a duty to steward resources and a duty to plan to ensure that HCIs can continue to meet safety needs of employees during situations such as the COVID-19 pandemic.

- Other duties/responsibilities of HCIs during the COVID-19 pandemic and beyond include: provision of education and training of employees and HCPs in risk reduction, mandatory vaccination policies, minimizing potential exposure, and disclosure of occupational risks.

Benedetti et al. argue that should a HCI fail to meet these duties/obligations towards its employees, this will influence the extend of the individual HCPs duties too.

- Next, the authors consider the practical question of whether HCPs can opt out of patient care responsibilities. a) if they are pregnant or b) on basis of conscientious objection to specific aspects of care for patients. The authors argue that decisions to allow HCPs to opt out must consider the individual HCPs perception of risk and the objective/technical risk and balance these carefully. HCIs must comply with non-discrimination laws, and HCIs will typically have policies in place that enable accommodation to employees who wish to avoid a particular work environment, for example, due to pregnancy. Policies pushing for mandatory exposure should be questioned, and decisions to let HCPs opt out might be justified in situations where the risk to HCPs are very high and the prognosis of the patient is very poor. Special attention should be paid to pressure on trainees that may unduly influence their opt-out decisions.
- On basis of the analysis, the authors outline a conceptual sliding scale model for health care providers duties based on the degree of technical risk to HCPs and the degree of benefit to patients. This evaluation framework/scale can be applied in determining the justification of policies for managing risks. At one end of the scale, where there is no risk to HCPs and high patient benefit, the default policy approach is mandatory participation in patient care. At the other end of the scale, where there is no patient benefit, and high risk to HCPs, the default policy approach is non-participation. Opt-in or opt-out policies may be justified depending on the level of technical risk on the sliding scale. A higher risk to HCPs combined with little patient benefit warrant opt-in policies, whereas a lower risk to HCPs combined with higher patient benefit warrant opt-out policies.

Conclusion

It is recognized that HCPs have a duty to assume risk when providing patient care. However, the degree of this duty may depend on the level of risk. HCI's duties to HCPs include the obligations to disclose and reduce risk associated with patient care. The sliding scale offers a framework for decision making and evaluation of existing policies relating to management of occupational risks in the health care setting.