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A qualitative study of the duty to care in communicable disease outbreaks

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Abstract

Health care providers' (HCPs') duty to care during communicable disease outbreaks has resurfaced as an important and contentious topic. This renewed interest follows the re-emergence of communicable diseases, largely thought to have disappeared and therefore irrelevant to modern day practitioners. The 2003 SARS outbreak particularly presented propitious circumstances for reconsidering this issue. This study seeks to characterize the views of individuals on the nature and limits of this duty.

The authors employed qualitative methods to gather lay and expert perspectives. Individual interviews were conducted with 67 participants consisting of HCPs, spiritual leaders, regulators, and members of the public from the greater Toronto area. Participants' views were analyzed and organized according to three main themes, constituting a framework that combines micro-, meso-, and macro-level structures and processes: the scope of obligations of HCPs, the roles of health care institutions, and the broader social context, respectively. Our data suggest that the duty to care must be placed in a wider context to include considerations that transcend individual provider obligations. It thus follows, based on our data, that the duty to care cannot be left to personal choice or an appeal to morality based on an ethic derived entirely from individual obligations.

The micro-meso-macro analytical framework that we have developed can guide the articulation of accepted norms of duty to care during epidemics and the development of policy for public health crises. It can also enhance the focus of our current expectations of HCPs' duty during epidemics. This can be achieved by informing regulatory bodies, collaborating with policy makers and engaging the public.

Keywords: Duty to care; Health care providers; Epidemics; Communicable diseases; Empirical; Qualitative; Canada

Introduction

In recent years, the duty to care of health care providers (HCPs) during communicable disease outbreaks has resurfaced as an important and

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contentious topic. The re-emergence of communicable diseases, which were largely thought to have become extinct (at least in North America) and therefore irrelevant to the modern day practitioner (Arras, 1988; Clark, 2005; Huber & Wynia, 2004; Lederberg, 1996; Morse, 2004; Patlak, 1996) has lead to renewed discourse on duty to care. In particular, the 2003 outbreak of severe acute respiratory syndrome (SARS) presented circumstances that were propitious for reconsidering this issue, namely the reluctance of some HCPs to care for patients suspected of infection by this unknown pathogen. While some simply refused to work, others seriously questioned the nature of their duty in light of unknown and unquantifiable risk to themselves and their families.

Drawing on the SARS experience in Toronto, Singer et al. (2003) re-emphasized that the nature of the duty to care is greatly contested. Some believe that under dire circumstances professionals should have minimal self-regard and pursue their duties at potential cost to their own lives, whereas others claim that it is unreasonable to demand extreme heroism as the norm, and even more unreasonable to demand that the lives of children and families should be endangered by professional duties. In turn, SARS fundamentally changed our assumptions about duty and risk—assumptions that had informed the debate on the duty to care in the early years of HIV/AIDS (Reid, 2005). Ruderman and colleagues called for an honest and critical examination of the role of HCPs during outbreaks in order to provide guidelines regarding professional rights and responsibilities as well as ethical duties and obligations (Ruderman et al., 2006). A social dialogue to advance the public debate on this increasingly urgent issue was needed.

More recently, the Joint Center for Bioethics (JCB) at the University of Toronto produced a report applying the ethical framework it developed in the context of SARS to planning for pandemic influenza (University of Toronto Joint Centre for Bioethics Pandemic Influenza Working Group, 2005). This report specifically addressed the challenges around the duty to care in pandemic planning, arguing that this issue ought to be one of the pillars of pandemic planning. The WHO also sought to address ethical issues in pandemic influenza planning, devoting one of its four reports to the roles and obligations of HCPs during a pandemic influenza outbreak (Upshur & Working Group Three, 14 September 2006).

A necessary next step to addressing these difficult issues is to understand the views of those most affected by the duty to care. Some have called for an investigation of this issue through empirical inquiry (Sokol, 2006), but to our knowledge, there has been no systematic analysis characterizing both lay and expert views regarding the duty to care of HCPs during outbreaks. The purpose of this study is to describe the views of members of the public, HCPs, regulators of professional colleges, public health officials, and spiritual leaders. We hope this analysis will serve to ground future discussion in the genuine beliefs and expectations of the lay public and experts, thereby lending an inherent authenticity.

Methods

Participants and setting

This study was undertaken in the Greater Toronto Area, a large, multi-cultural urban center that was significantly impacted by the SARS outbreak. In order to gather multiple perspectives, participants were drawn from the following five groups: HCPs, members of the public, public health officials, regulators of provider colleges, and spiritual leaders, including participants who were directly or indirectly impacted by the SARS experience in Toronto. We sought the views of some public health officials outside of Toronto as they deal with the question of duty to care in other public health contexts and thus have an informed perspective on the matter.

Lay participants and HCPs were recruited using newspaper advertisements. Spiritual leaders and regulators were invited to participate by letter. Participants were further recruited by way of snowball sampling. A total of 67 participants were interviewed, consisting of 25 HCPs (1 paramedic, 1 respiratory therapist, 3 social workers, 7 physicians, 13 nurses), 14 spiritual leaders (8 Christian, 2 Buddhist, 2 Jewish, 1 Muslim, 1 Sikh), 12 members of regulatory Colleges, 10 members of the public, and 6 public health officials. The large majority of HCPs and five spiritual leaders worked in a SARS-designated hospital. All participants provided informed consent (either in writing or verbally). The study received ethics approval from the University of Toronto and the Hospital for Sick Children.