



Beyond Duty: Medical “Heroes” and the COVID-19 Pandemic

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Abstract When infectious disease outbreaks strike, health facilities acquire labels such as “war zones” and “battlefields” and healthcare professionals become “heroes” on the “front line.” But unlike soldiers, healthcare professionals often take on these dangerous roles without any prior intention or explicit expectation that their work will place them in grave personal danger. This inevitably raises questions about their role-related obligations and whether they should be free to choose not to endanger themselves. In this article, I argue that it is helpful to view this situation not only through the lens of “professional duty” but also through the lens of “role-related conflicts.” Doing so has the advantage of avoiding exceptionalism and allowing us to draw lessons not only from previous epidemics but also from a wide range of far more common role-related dilemmas in healthcare.

Keywords COVID-19 · Coronavirus · Pandemic · Duty to care · Professional duties · Role-related conflicts · Conflict of interest

Almost as soon as the COVID-19 pandemic emerged, a narrative about healthcare “heroes” appeared in the popular media. According to this narrative, healthcare workers (HCWs) are marching to the “frontline” in the “war”

(McMillan 2020, ¶2) against the virus and, in doing so, are putting themselves at considerable risk. These “heroic” HCWs have since been the subject of coordinated public applause (Hurst 2020), serenaded by famous singers (Chan 2020), and profiled in the media (Knapp 2020). Funds have been raised to demonstrate appreciation for their sacrifices (The Common Good 2020), lines of “Thank You Heroes” action figures (O’Kane 2020) and “health hero” stock photographs have been released (Shutterstock 2020), and it is even being predicted that statues will be erected in their honour (Lake 2020).

While some HCWs have expressed appreciation for these “signs of love from the community” (Gavin 2020, ¶26) that “help us trudge on” (Kane 2020, ¶31), others have begun to push back against the hero narrative. In some cases, this is because they don’t see themselves as heroes, because they are simply doing what they “have always done” (*KevinMD Blog* 2020, ¶1). In other cases it is because it is they associate heroism with lack of fear—and they are afraid (Lake 2020; Kane 2020). And in other cases, it is because they see the hero narrative as a means by which the public and politicians can assuage their guilt and feign appreciation despite acting for decades in ways that actively undermine health services, failing to prepare adequately for the pandemic, and, now, failing to engage in adequate social distancing and provide HCWs with adequate personal protective equipment (PPE) (Darlow 2020; Miller 2020; Mathers and Kitchen 2020):

Private businesses and citizens are offering generous displays of public support for their doctors and nurses, cheering for them every evening, buying

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them dinner in hospital wards, and thanking them profusely for their service. But institutions, at the same time, are letting them down. (Khetpal 2020, ¶10).

Indeed, for many HCWs, the shortage of PPE is not only seen a failure of society's duty of care—"as if our government has condoned sending our front lines into battle without helmets or bullet-proof vests" (Guzzi 2020, ¶4)—but also as a failure to reciprocate for the personal risks that HCWs are taking:

If health-care providers are going to risk their life, then there is a reciprocal obligation—the *fairness principle*—that society, employers and the hospitals keep them safe and ensure that they are fairly treated, whether they live, get sick, or die. (Kirsch 2020, ¶21)

For some HCWs, the moral injury associated with lack of reciprocity has exacerbated their sense that they are being "bullied," "shamed," and "emotionally blackmailed" by hospital managers and government for demanding or allegedly misusing PPE (Child 2020, ¶14; Hammond 2020, ¶9). This appears particularly the case for non-physician HCWs, those from ethnic minority groups, and those working in less resourced areas, who already face disadvantages and inequities and have the sense that they are now being placed at disproportionately high risk (Covert 2020; Ford 2020). Similar concerns about reciprocity have emerged in discussions of reimbursement, with HCWs complaining about being asked to accept reduced hours or leave without pay (Maass 2020) and some medical students even being asked to work as "meat shields" without any pay at all (Khetpal 2020, ¶10).

While HCWs frequently emphasize the strength of their calling to help and insist that they will push on despite the lack of PPE and other forms of reciprocity (Covert 2020; Guzzi 2020), concerns have begun to emerge that HCWs might begin to refuse to care for COVID-19 patients or leave the workforce altogether if they feel insufficiently respected and cared for (Bieman 2020; Jauhar 2020):

... a tipping point could happen with little warning. The loss of providers will come from many causes—quarantine, sickness, caring for their own family, cohorting—but it will be the creeping fear and feeling of abandonment that eats at us the most. (Kirsch 2020, ¶31)

Indeed, there have already been cases of HCWs protesting and even striking over lack of adequate PPE and other perceived forms of mistreatment by governments or hospital administrators (Anadolu Agency 2020; Jeffery 2020).

The "Duty to Care" and its Limitations

Both the hero narrative and counter-calls for reciprocal protection reflect the major themes within the bioethics discourse on patient care during infectious disease outbreaks. This discourse focuses primarily on the moral bases of HCWs' so called "duty to care," including both general duties and virtues such as altruism, beneficence, non-abandonment, justice, and solidarity (Klopfenstein 2008; Vawter et al. 2008; Lowe, Hewlett, and Schonfeld 2020; Sawicki 2008) and more specific professional duties. The foundations of these specific moral duties (which, in this context, refer primarily to obligations to individuals or groups) have been variously framed in terms of HCWs' status as healing professionals, their voluntary choice to enter risky occupations and professions, their obligation to repay society for its investment in their training and for the professional privileges they enjoy, and their special training which means that they are both the most skilled and the "safest" providers of care during infectious disease outbreaks (Clark 2005; Malm et al. 2008; Dawson 2016; Daniels 1991; Mareiniss 2008; Huber and Wynia 2004; Sawicki 2008).

It is, however, broadly recognized that HCWs have only a *qualified* duty to act during pandemics as a consequence of the magnitude of the risks that they face and the competing duties that they have to themselves, their families, and other (non-infected) patients (Bailey et al. 2008; Reiheld 2008; Malm et al. 2008; Sokol 2008; Dawson 2016). Many bioethicists also argue that HCWs have entered into a broad social contract that not only creates their duty to care but also places obligations on society to keep them as safe as possible and reward them for their sacrifices (Reid 2005; Joint Centre for Bioethics Pandemic Ethics Working Group 2008; Millar and Hsu 2019; Dawson 2016; Solano et al. 2015; Dwyer and Tsai 2008). In the context of COVID-19, ethicists have argued that, while there is a duty to care, this duty is context-specific (e.g., depending on the likelihood of a patient benefiting from care, the HCW's training, and their personal health status)

and holds only if there is adequate planning and reciprocity in the form of PPE, reasonable shift schedules, professional acknowledgement, financial compensation, social and psychological support, information and training, testing and monitoring, and (more controversially) protection from litigation and priority access to critical care (Schuklenk 2020; Dunn et al. 2020; Hick et al. 2020; British Columbia Ministry of Health 2020).

Beyond the Duty to Care

Such articulations of HCWs' duties (and their limits) are important because they inform the design of systems and processes and justify limited incursions on HCWs' choices. But there is evidence from the emerging COVID-19 discourse that abstract appeals to duty might not resonate with the intuitions that HCWs have about their reasons for doing the work they do:

... the hair stands up on the back of my neck when I hear ethicists, hospital administrators, and politicians, sitting in their safe offices, lecture me on my obligation to die providing health-care. We don't take these risks because of an abstract "ethical duty"; we take them because it is what we do every time we walk into the chaos and danger of the emergency department. We do it because it is our job. (Kirsch 2020, ¶18)

Another problem with appeals to duty is that they do not focus squarely enough on the moral and associated psychological conflicts that HCWs experience:

... this argument [about duty] seems to minimize the quandary my colleagues are facing as they try to balance their obligations as professionals with their duties as husbands, wives, parents and children. (Jauhar 2020, ¶4)

While providing HCWs with PPE, assurances of care, and other act of reciprocity will no doubt go some of the way toward addressing such "quandaries," it cannot eliminate all personal risk and, therefore, all conflict.

The question therefore arises: if moral conflict in infectious disease outbreaks cannot be completely managed—and might actually be exacerbated—by abstract appeals to a "duty to care," how (else) might we think about and manage the moral conflicts experienced

by HCWs during pandemics? In what follows, I will argue that useful lessons can be drawn from other situations in which HCWs' obligations to their patients are in tension with personal desires or other obligations—that is, from other "role-related conflicts."

Professional Roles and Role-Related Conflicts

Like all professionals, HCWs occupy a wide variety of roles, including those directly related to their occupation (e.g., carer, resource allocator, researcher, hospital employee, consultant, colleague, clinic owner). At the same time, HCWs also inevitably occupy a number of roles that are more peripherally related or unrelated to their healthcare work but which might impact on, or be impacted by, their HCW roles. These include being an equity holder in an external organization, an advocate for a personal belief or cause, a member of a community (e.g., recreational, political, or religious) organization and, of course, a family member, friend, and so on.

Each of the abovementioned roles and role-related activities is associated with a set of "interests." While there is no simple agreed-upon definition of an interest, the term generally refers to the desires and obligations associated with a role or role-related activity (Komesaroff, Kerridge, and Lipworth 2019). Desires can be both financial and non-financial, and include the pursuit of material goods, as well as the desire to remain safe, to promote or enact one's religious beliefs, or to achieve personal and professional status, while obligations can be to patients, healthcare systems, the general population, employers, or the research endeavour.

In most situations, interests coexist without obvious tension and may even support and reinforce each other. In these cases, one might be said to have a "duality" or "multiplicity" of interests. There are, however, situations in which acting on the desires or obligations associated with one role or role-related activity impedes one's capacity or willingness to fulfil the obligations associated with another role. When this occurs, a "role-related conflict" (or "conflict of interest") can be said to exist. While many role-related conflicts can be managed simply (e.g., through disclosure and recusal from particular activities) they may also sometimes be unacknowledged or difficult to manage, resulting in professional bias and harms to individuals, populations, organizations, and systems (Komesaroff, Kerridge, and Lipworth 2019).

When the conflict faced by HCWs during pandemics between protecting their own health and safety and providing patient care is placed in this context, it becomes clear that this is just one of many types of role-related conflicts in which interests compete or conflict. Other key examples of similar role-related conflicts include HCWs who wish to, or are expected to, consider macro resource allocation issues when caring for individual patients; HCWs who own, or hold shares in, clinics or healthcare companies; HCWs who are employed by, or consult to, private companies, government agencies, insurance companies, or patients' employers; and HCWs who are engaged in both patient care and clinical research.

When the discourses surrounding these role-related conflicts are systematically examined, two things become evident: first, there are many different ways of thinking about the circumstances under which HCWs should, and should not, be permitted to attend to interests other than patient care (i.e., to deprioritize patient care); and second, there are many different practical strategies for managing the conflicts that arise between duties to patients and other competing desires and obligations. Many of these insights can be translated to the role-related conflicts that arise during infectious disease outbreaks.

Justifying the Deprioritization of Patient Care

As described above, the discourse surrounding the duty of HCWs to provide care during infectious disease outbreaks focuses primarily on the reasons that they might be seen to have such a duty, the factors that limit that duty, and the importance of reciprocity as part of the broad social contract in which the duty is situated. In this regard, discussions about the duties of HCWs in pandemics are no different to discussions of many other types of role-related conflicts in that these also focus squarely on the concept of duty and its qualifications. This is most obvious in discussions of conscientious objection, where HCWs' freedom to act on their personal beliefs is challenged on the grounds that they have a duty to provide the full range of healthcare services (Curlin and Tollefsen 2019). The idea of duty also emerges as a counterpoint to the idea that HCWs should be free to consider macro-level resource allocation when deciding what interventions to offer their patients (Tilburt 2014), to recruit their own patients to clinical

trials (Morain, Joffe, and Largent 2019), or to engage in private business activities (Humbyrd and Wynia 2019). All of these activities are discouraged, at least partly, on the grounds that they potentially conflict with HCWs' (more important) duties to their patients.

While discourses about other role-related conflicts mirror the "duty to care" discourse to some extent by focusing squarely on the concept of duty, they also bring to light reasons *other than duty itself* for limiting HCWs' autonomy and preventing them from acting on their competing interests. Some of these reasons are ontological—for example, it is argued that HCWs should not be free to act on their consciences because "conscience" is itself a problematic construct (Churchill 2019). Other reasons are epistemological—HCWs should not be free to act on competing interests because there are no sufficiently coherent grounds on which such actions can be justified and limits set (Sepper 2019; Tilburt 2014; Glover 2019). And others are consequentialist, the focus being on the effects of deprioritizing patient care on the image of medicine, on trust in HCWs, on patient welfare and population health, on social justice, and on the HCW–patient relationship itself (Abrams 1986; Sulmasy 1992; Magelssen, Le, and Supphellen 2019; Riggs and DeCamp 2014; Gostin 2019). Of course, there are complex relationships between duties and consequences, and some accounts of duty (e.g., rule deontology) position them primarily as routes to desirable consequences. But a consequentialist approach reminds us that consequences (and therefore the actions that produce them) can matter irrespective of whether a duty is believed to exist.

Focusing on the discussions that surround other kinds of role-related conflicts also reminds us that there are many factors that need to be taken into consideration when deciding whether the duty to care for patients can be overridden *in a particular context*. These include not only the likely benefits and risks of acting in that particular context (Riggs and DeCamp 2014; Wicclair 2019; Morain, Joffe, and Largent 2019), but also whether the professionals involved have (other) conflicts of interest that are driving their behaviour (Wilfond and Porter 2019) and whether the action is justified publicly or privately on the basis of robust moral argumentation (Nussbaum 2019; McConnell and Card 2019). Discourses about other role-related conflicts also remind us of the possibility of "role morality," in which HCWs adhere wholeheartedly to their primary obligations when engaged in patient care but satisfy other desires and obligations at other times (Tilburt 2014).

Some of these insights could be, but rarely are, applied to consideration of the issues surrounding the duties of HCWs during a pandemic. For example, beyond the obvious fact that patients will be neglected if HCWs refuse to care for them, there is currently little nuanced and systematic thinking about the harms and benefits of HCWs excusing themselves (partially and completely) from different kinds of caring activities during epidemics. There is also only passing mention of the need for clear professional standards (Clark 2005) and public justification of decisions to abstain from patient care (Joint Centre for Bioethics Pandemic Ethics Working Group 2008), and it is not at all clear what these standards and justificatory principles should be. In this regard, it is noteworthy that guidelines for HCWs caring for COVID-19 patients sometimes insist on HCWs having to provide robust and specific justification for their decisions (British Columbia Ministry of Health 2020; General Medical Council 2020) but do not fully articulate what would constitute a sufficient justification. More attention could also be paid to whether there are interests other than personal safety that are driving HCWs away from patient care (e.g., unreasonable financial expectations). And thought could be given to what “role morality” might look like in an epidemic context; for example, HCWs who remove themselves from patient care could be involved in other aspects of epidemic management.

Preventing and Managing Role-Related Conflicts

In addition to enriching our thinking about the circumstances under which HCWs might be justified in deprioritizing patient care, attention to other role-related conflicts can also provide practical guidance as to the strategies that can be put in place to manage role-related conflicts such as education, psychological support, disclosure, recusal, and harm minimization. Some of these practical conflict management strategies have been used in infectious disease outbreaks and are currently being used for COVID-19 workforce management. For example, efforts are already being made to limit the burden on HCWs by minimizing community transmission. Healthcare systems are already attempting to minimize the harms of recusal by redistributing HCWs and calling on volunteers. And HCWs are already being provided with education and (in most cases) with physical, social, and psychological support.

Translating strategies from other contexts to that of infectious disease outbreaks also brings to light new policy options. For example, more attention could be paid to training of HCWs (ideally in advance of life-or-death decision-making) so that they understand the nature of, rationale for, and limits to their professional obligations during epidemics. More systematic attention could also be paid to the kinds of psychological support they need—not only to manage the usual stressors of caring for very ill patients but also the distress that comes from being uncertain about whether they want to care for their patients at all. These issues are currently only hinted at in existing psychological guidelines. For example, guidelines recently produced by the British Psychological Association Covid19 Staff Wellbeing Group (2020) refer only obliquely and in passing to the “resentment” (Table 1 in BPA document) that HCWs might experience as a result of the risks and costs to themselves and their families. Finally, central registers could track how many HCWs recuse themselves (or plan to recuse themselves) from patient care, for what reasons, and with what effects on both the workers and their colleagues and patients. This monitoring could be both quantitative and qualitative so that nuanced reasons for recusal become clear and so that tailored measures can be put in place to address specific types and causes of moral conflict. This would also facilitate the kinds of justificatory process discussed above when HCWs are asked to explain why they have chosen to excuse themselves from patient care.

Conclusion

It is possible that there might be some resistance to the idea of placing HCWs who experience moral conflicts during epidemics in the same category as those who have other—more morally questionable—types of “conflict of interest.” It is important, however, that this anxiety is overcome, as taking a non-exceptionalist approach to this issue—in which the dilemma associated with the “duty to care” during epidemics is viewed as just one of the many other types of role-related conflicts that HCWs experience—may provide important conceptual and practical insights. While there are ongoing debates about how we should manage all types of role-related conflict, viewing them all as instances of a single phenomenon prevents us from starting from scratch with every instantiation and enables us to learn from

other, at least partly analogous, situations. Whether or not one accepts this broader framing of the problem, it is clear that referring to health workers as heroes is neither necessary nor sufficient for managing their role-related conflicts during epidemics and the notion of reciprocal social duty does not, on its own, fill the gap.

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