THE NATIONAL CATHOLIC BIOETHICS CENTER
6399 Drexel Road, Philadelphia, PA 19151 Tel. 215-877-2660 Fax. 215-877-2688 www.ncbcenter.org

**The Duty to Care during a Pandemic**

**Philip Cerroni, DiAnn Ecret, RN, and Edward. J. Furton**

Is it ethically justifiable for an experienced, licensed, and competent health care worker to withdraw from his or her duties of care during a pandemic such as the current COVID-19 global health crisis? During a pandemic, health care workers face a difficult decision whether to carry out their normal care duties or, in addition, to activate for front line relief. Self-isolation will help protect health care workers and their families from exposure to a highly infectious, communicable contagion such as SARS-CoV-2; however, a health care worker's absence may result in patients' not receiving needed care. Ultimately, this decision is a prudential one, which requires an understanding of moral principles, valid ethical reasoning, and accurate medical knowledge.

## The Special Role of Health Care Workers

Before evaluating specific aspects of the moral act or weighing potential benefits and harms, any ethical analysis must recognize the special role of health care workers in society, which presupposes a "duty to care" during an emergency. Marie Hilliard identifies three primary justifications for this duty:

1. "Health care professionals have a proportionally greater ability (than the public) to provide care."
2. "Professionals, in choosing their professions, have assumed the risks of providing care."
3. "Professionals are legitimated by their contracts with society."[1]

The exercise of this freely chosen profession in times of emergency may appear to be a social convention or a mere contractual agreement, but natural law reasoning suggests that it is a fundamental, enduring aspect of the role of the medical profession. Nevertheless, although the societal contract holds for all health care workers in a general sense, the precise "terms" of each contract are determined case by case on the basis of the health care worker's ability to effectively carry out his or her duties during a specific health crisis. For instance, less would be expected of a health care worker whose age or preexisting conditions (e.g., obesity, cardiovascular disease, or chronic obstructive pulmonary disease) place him or her at great risk and vulnerability than would be expected of a person without these preexisting conditions.

The *Ethical and Religious Directives for Catholic Health Care Services* (*ERDs*) appeal to basic human rights when describing the mission of health care, which "is rooted in a commitment to promote and defend human dignity; this is the foundation of its concern to respect the sacredness of every human life. … The first right of the human person, the right to life, entails a right to the means for the proper development of life, such as adequate health care."[2] However, as observed by Popes Paul VI and Benedict XVI, this

---

[1]Marie T. Hilliard, "The Duty to Care. When Health Care Workers Face Personal Risk," *National Catholic Bioethics Quarterly* 17.4 (Winter 2007): 676, doi. 10.5840/ncbq2007743.
[2]US Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services* (*ERDs*), 6th ed. (Washington: DC, USCCB, 2018), part 1, intro.

right to adequate health care does not exist in a vacuum: "'The reality of human solidarity, which is a benefit for us, also imposes a duty.' … *Rights presuppose duties*. … Duties thereby reinforce rights and call for their defense and promotion as a task to be undertaken in the service of the common good."[3] If people have a right to adequate care, then the duty to preserve that right rests with those individuals who are capable of doing so. So it appears that there is an in-principle right to care and that the duty to preserve this right rests with health care workers.

**Formal Duty of Health Care Workers**

This duty appears to be an essential disposition rather than a role that can be assumed or discarded. The *ERDs* assert that the role of health care is more than a professional choice. It is "a special vocation to share in carrying forth God's life-giving and healing work" (general introduction). Usually vocation is understood in terms of human beings' universal "eternal vocation." However, this is lived out in "the most common of social realities" through a person's "social vocation."[4] As the means by which people carry out their universal vocation, social vocations would seem to share in this underlying and more fundamental permanence.

[3]Benedict XVI, *Caritas in veritate* (June 29, 2009), n. 43.
[4]Vatican Council II, *Gaudium et spes* (December 7, 1965), nn. 32, 76.

The obligations required by social vocation can be understood more clearly in relation to the definition of *state* (*status* in Latin) given by Thomas Aquinas in his examination of the duties and states of human beings: "[State] regards a condition of the person himself … [and] denotes a kind of position, whereby a thing is disposed with a certain immobility [i.e., permanence] in a manner according with its nature." In other words, the vocational state has an enduring character that belongs to it by nature. Furthermore, this state includes "an obligation binding his person, in so far, to wit, as a man is his own master or subject to another."[5] In this view, a person's state, or vocation, carries with it certain temporal obligations.

It seems self-evident that it is in the nature of the health care profession to provide medical care, and this common understanding has been reiterated axiomatically throughout history. Hippocrates declared that physicians have "two special objects in view with regard to disease, namely, *to do good* or to do no harm."[6] Sixteenth-century surgeon Ambroise Paré penned the now-famous motto of palliative care, "To cure sometimes, to relieve often, and to comfort always."[7] Even Aristotle, when describing nature and causes, used the example of a physician as the a priori cause of health.[8] Aquinas's view on state is reflected in Hilliard's perspective on the position of health care workers in society, both in their ability, by nature of their profession, to carry out certain duties "proportionally greater … than the public" and in their position "legitimated by their contracts with society."

---

[5]Thomas Aquinas, *Summa theologiae* (*ST*), trans. Fathers of the English Dominican Province (1920), II-II.183.1 corpus and ad 3.
[6]Hippocrates, *Of the Epidemics*, trans. Francis Adams (1849), II.5, emphasis added.
[7]Vicki Lachman, *Ethical challenges in health care: Developing your moral compass* (New York: Springer, 2009), 101.
[8]Aristotle, *Metaphysics*, trans W.D. Ross (1923), 5.2.

6399 Drexel Road, Philadelphia, PA 19151 Tel. 215-877-2660 Fax. 215-877-2688 www.ncbcenter.org

Hippocrates also alludes to this professional obligation when he writes, “The physician is the servant of the art.”[9]

**Adequate Care**

At this point, we have sketched a picture of health care workers’ duty to care, which is grounded in human nature, vocation, and the nature of the medical profession, as understood for millennia and across medical-moral traditions. Although we have described how the duty of health care workers cannot merely be assumed or discarded at will, we still must determine what care patients have a right to receive as adequate.

It would seem that patients have a right to the same care that they are morally obligated to seek for themselves. The *ERDs* identify this is *proportionate means of preserving life*: “Those that in the judgment of the patient offer a reasonable hope of benefit and do not entail an excessive burden or impose excessive expense on the family or the community” (dir. 56).

Hilliard proposes four criteria for obligatory care, from the perspective of heath care workers, that align with this understanding of proportionate means:

1. “The patient is at significant risk of harm, loss, or damage if the [health care worker] does not assist.”

[9]Hippocrates, Epidemics II.5.

2. “The [health care worker’s] intervention or care is directly relevant to preventing harm”
3. “The [health care worker’s] care will probably prevent harm, loss, or damage to the patient”
4. “The benefit the patient will gain outweighs any harm the [health care worker] might incur and does not present more than an acceptable risk to the nurse.”[10]

During a pandemic, the first element clearly is present. The second and third depend on the health care worker’s specific role. Nurses in the intensive care unit meet these criteria more obviously than do brain-imaging technicians or medical records clerks, and the decision not to activate is more likely to be licit for support staff than for nurses. The fourth criterion requires more careful discernment, and when considering the harms that might accrue to health care workers and their families, these individuals should divided into two groups on the basis of the harm they may incur.

## Proportionate Means of Preserving Health

When discerning whether to activate during a pandemic, health care workers should consider the principle of proportionality. That is, if staying home to protect one’s health or the health of one’s family’s is a proportionate means of preserving health, then it seems to be morally permissible. In this scenario, not activating is proportionate if it (1) offers a reasonable hope of protecting oneself or one’s family, and (2) it does not impose excessive burden on the community. Both conditions must hold.

---

[10]Hilliard, “The Duty to Care,” 678.

THE NATIONAL CATHOLIC BIOETHICS CENTER
6399 Drexel Road, Philadelphia, PA 19151 Tel. 215-877-2660 Fax. 215-877-2688 www.ncbcenter.org

The first point is simple enough. Not activating does provide a benefit of less risk. However, this is not sufficient, and one must discern whether greater protective benefit is conveyed by staying home, compared with going to work and following appropriate personal protective procedures. The answer to this question rests in part with the workplace—namely, has the site taken adequate safety measures such as providing personal protective equipment? This raises organizational ethics questions regarding institutions' and governments' responsibility to protect the care provided by their agents and to foster principles and policies that support the just allocation of resources.

When measuring personal risk and weighing the adequacy of safety measures, it is important to look to organizations such as local, state, and federal public health agencies, as they are the competent authority to judge risk in these matters. Additional sources such as studies published in peer-reviewed journals also inform an objective assessment of risk. The prudential decision of whether to activate during a pandemic must be informed by accurate medical knowledge.

Yet the vocation of the health care worker means that fulfilling the above conditions is not sufficient for excusing oneself from professional duties. A health care worker's absence represents an excessive burden to the community if patients are at significant risk of harm, which the health care worker's care probably would prevent, and the health care worker is not at more than acceptable risk.[11]

[11]Ibid., 673–682.

To examine these criteria, health care providers should be separated into two categories: those who are or have family members at high risk and those who do not. Here it is presumed that in high-risk individuals, infection will result in serious, perhaps life-threatening disease.

In principle, not activating would be proportionate for providers in the first group. Since infection could result in serious injury or death, there is a real benefit to reducing the chances of infection. If a health worker himself or herself is at high risk, not activating is a proportionate means of preserving health. Regardless of workplace safety measures, a high-risk person is not obligated to expose oneself to serious illness. Nevertheless, these health care workers should explore other ways in which they can assist, for example, by providing telehealth services or assuming administrative or other duties behind the front line of care.

If a health care worker is not at high risk but lives with an individual at high risk, not activating still might be proportionate because health care workers have a responsibility to care for the health of their families as well as of other members of the community. Indeed, this primary obligation to family is required under the principle of subsidiarity. However, health workers should consider whether there are other ways to protect their loved ones, for example, by staying someplace else during the emergency or finding a safer place for their high-risk family members to stay.

Health workers who are not at high risk and do not have family members at high risk must ask themselves whether prevention is a proportionate reason not to activate. In the previous situation, infection would lead to serious harm. However, if the disease does not pose a serious risk to one's health, the burden on the community and the individual's

THE NATIONAL CATHOLIC BIOETHICS CENTER
6399 Drexel Road, Philadelphia, PA 19151 Tel. 215-877-2660 Fax. 215-877-2688 www.ncbcenter.org

duty to care for the sick would seem to outweigh dangers of contracting the disease. Moreover, as stated previously, the assessment of risk must be based on the best available, objective scientific knowledge (which likely will evolve as more data becomes available during an emergency situation) and not founded on fears or a sense of alarm. The mere possibility of contracting a disease is not a sufficient reason to excuse oneself from activation. The vocation of the health care worker is essentially bound up with caring for others, and this necessarily leads to the acceptance of an increased level of risk, just as it does for law enforcement and military personnel. A common military axiom sums up the relationship with society: A veteran is someone who, at one point, wrote a blank check made payable to the American people for an amount up to and including life.[12]

Although health care workers are vitally important figures in times of pandemic—and therefore in case of illness should receive care before others—the possibility of convalescence following an illness should not be a factor in deliberating about whether to activate. The profession obliges health care worker to accept a higher level of risk than those who do not have similar obligations. A health care worker who contracts an illness will obviously be excused from service during the time that he or she is recuperating.

In some cases, individual exposed to or infected by a disease acquire immunity, although the likelihood varies among bacteria, viruses, and so on.[13] During a pandemic, the

[12]Although the more common phrasing is "to the United States of America," the alternative wording, which at least is used in the Marine Corps, is more telling.
[13]John B. Robbins, Rachel Schneerson, and Shousun C. Szu, *Medical Microbiology*, 4th ed. (Galveston, TX: University of Texas Medical Branch at Galveston, 1996), chap. 8.

possibility of acquired immunity makes these workers all the more valuable to the community because it is unlikely that they will succumb the disease a second time, and therefore they may carry out their healing roles with greater security and confidence. Thus some measure of risk taking may confer benefits on the health care worker as well as on society as a whole. However, taking greater risks in the hope of developing acquired immunity undoubtedly is an extraordinary means and would be permissible only when it is reasonably certain (in light of the best available medical knowledge) that health care workers (1) are placing themselves at no greater risk than they already would be obliged to take and (2) will develop acquired immunity.

Admittedly, it might not be immediately intuitive to adapt bioethical principles regarding benefit, risk, and harm—which generally deal with the decisions that are made by or for patients regarding their care—to the heath care workforce. Nevertheless, there is an analogy to pursuing extraordinary means of preserving one's life. Catholic bioethics has consistently held that there is no intrinsic obligation to pursue extraordinary—that is, overly burdensome—means of preserving one's life. However, some people can have a "per accidens" obligation to accept extraordinary burdens—such as placing oneself at great risk—if one is "especially necessary to … society."[14] Health care workers would seem to fall into this category.

In addition to the higher professional standards that attaches to the health care worker, the Christian may have duties that exceed those of other workers in this field. Christ's mandate that we heal the sick cannot be lightly set aside and may demand actions that go beyond what would be obligatory as determined by a purely natural law analysis.

---

[14]Daniel Cronin, *Ordinary and Extraordinary Means of Conserving Life*, fiftieth anniversary ed. (Philadelphia: National Catholic Bioethics Center, 2011), 163.

6399 Drexel Road, Philadelphia, PA 19151 Tel. 215-877-2660 Fax. 215-877-2688 www.ncbcenter.org

Although a reckless disregard for one's own health can never be justified by faith, and our duties to family take precedence over those to society, there is nothing to prevent a Christian health care worker from going beyond the norm and carrying out actions that would be considered heroic in ordinary times.

**Care Delivery during COVID-19**

Although the principles and argument regarding adequate care, appropriate safety measures, and high risk hold across cases in a general sense, this section examines them in the context of the current COVID-19 pandemic.

*Adequate Care*

When evaluating the specific means of adequate care— to which patients have a right—in the context of COVID-19, it is helpful to consider the relative norm of proportionality, namely, the obligation to pursue "means in common use." In other words, adequate means of care are those that people "commonly use… in the quantity which customarily suffices for the conservation of strength."[15] (This is synonymous to an evaluation of ordinary vs extraordinary means.) Patients have a right to the effective treatments that generally are available to others in their clinical condition and situation. Note that adequate care can

[15]Francisco de Vitoria, *Commentarios a la secundae* 147.1, cited in Cronin, *Ordinary and Extraordinary*, 129. Vitoria is talking specifically about the obligation of a patient to seek certain means of conserving life. However, the analogy seems appropriate.

differ among institutions on the basis of resources and case load, for example, rural vs large academic hospitals and those in hard-hit vs less-affected regions.[16] (Of course, the availability of certain treatments, especially those that should be commonly available, is an institutional ethics issue.)

What are these common means in the context of COVID-19?[17] Adequate care comprises symptom management, supportive care, and off-label antiviral and antimalarial medical when appropriate. In general, these involve care and medications that are readily available and, in principle, that are adequate care. However, the scarcity of medical devices such as mechanical ventilators—and even limited access to health care providers—might make some treatments extraordinary under certain circumstances. Common symptoms of COVID-19 include fever, cough, and difficulty breathing. In mild cases, these can be alleviated inexpensively and with relative ease using nonsteroidal anti-inflammatory drugs (fever), antibiotics (pneumonia and secondary infections), oxygen through nasal cannula or a face mask (difficulty breathing), and so on.[18] Supportive care includes bedrest, nutrition, hydration, electrolytes, and medication or dialysis to assist kidney function (acid–base homeostasis).[19]

The means required to treat severe symptoms and complications may exceed adequate care, especially as health care systems become overburdened. More serious cases

[16]Cronin, *Ordinary and Extraordinary*, 132.
[17]COVID-19 has been described as a severe respiratory illness, more specifically, a pneumonia of unknown origin. Mary A. Lake, “What We Know So Far: COVID-19 Current Clinical Knowledge and Research,” *Clinical Medicine* 20.2 (March 2020): 124–127, doi: 10.7861/clinmed.2019-coron.
[18]Sasmita P. Adhikari et al., “Epidemiology, Causes, Clinical Manifestation and Diagnosis, Prevention, and Control of Coronavirus Disease (COVID-19) during the Early Outbreak Period: A Scoping Review,” *Infectious Diseases of Poverty* 9.1 (March 17, 2020): 1–12, doi: 10.1186/s40249-020-00646-x.
[19]Taisheng Li, “Diagnosis and Clinical Management of Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2) Infection: An Operational Recommendation of Peking University Medical College Hospital (V2.0),” Emerging Microbes and Infection 9.1 (March 14, 2020): 582–585, doi: 10.1080/22221751.2020.1735265.

are characterized by progressive respiratory failure and multiple organ failure.[20] Even patients with mild cases might need nasal cannula or noninvasive ventilation, and those who present with more severe symptoms might need mechanical ventilation or extracorporeal membrane oxygenation (ECMO).[21] Finally, complications vary in severity. Medication can be given for some, including arrythmia and secondary infections. Others—such as acute kidney shock and acute respiratory distress syndrome (ARDS)—require increasing levels of care, which might be considered extraordinary.[22]

The use of experimental antiviral drugs or off-label medications such as chloroquine or lopinavir/ritonavir are not in-principle adequate care.[23] Nevertheless, off-label use of approved medications could be considered adequate if they are in sufficient supply and if the attending physician considers their use to be proportionate. When a vaccine or antiviral treatment becomes widely available, this would be considered adequate care. If there is a shortage of either countermeasure, a question of just distribution of resources arises. In such a case, antiviral treatments should be reserved for individuals at greatest risk of death. Vaccines present a different scenario, and various authors suggest

[20]Adhikari et al., "Epidemiology," 1–12; and Yan-Rong Guo et al., "The Origin, Transmission and Clinical Therapies of Coronavirus Disease 2019 COVID-19) Outbreak—An Update on the Status," Military Medical Research 7.1 (March 13, 2020): 1–10, doi: 10.1186/s40779-020-00240-0.
[21]Li, "Diagnosis and Clinical Management," 582–585; and Tanu Singhal, "A Review of Coronavirus Disease-2019 (COVID-19)," *Indian Journal of Pediatrics* 87.4 (April 2020): 281–286, doi: 10.1007/s12098-020-03263-6.
[22]Guo et al., "Origin, Transmission and Clinical Therapies," 1–10.
[23]Christian A. Devaux et al., "New Insights on the Antiviral Effects of Chloroquine against Coronavirus: What to Expect for COVID-19?," International Journal of Antimicrobial Agent, e-pub March 11, 2020, doi: 10.1016/j.ijantimicag.2020.105938; and Jaegyun Lim et al., "Coronavirus Disease 2019 in Korea: The Application of Lopinavir/Ritonavir for the Treatment of COVID-19 Pneumonia Monitored by Quantitative RT-PCR," Journal of Korean Medical Science 35.6 (February 17, 2020): 1–6, doi: 10.3346/jkms.2020.35.e79.

that first responders, health care workers, and their families should be vaccinated first alongside individuals at high risk.[24]

*Appropriate Workplace Safety Measures*

Health care institutions have a duty to make the care environment as safe as possible for health care workers. In the case of COVID-19, this means preventing droplet, contact, and aerosol transmission of infected fluid, phlegm, and so on. It is reasonable to expect all facilities to have proper hygiene, disinfecting, and decontamination procedures. However, the scarcity of personal protective equipment, including masks, respirators, suits, and eye protection makes providing care increasingly dangerous for health care providers.[25]

A common and somewhat ironic observation in bioethics is that we can get ourselves into situations from which there is no ethical way out. In the current case, patients have a right to adequate care, which health care workers have a duty to provide. But governments and institutions cannot ethically order health care workers into a dangerous situation for which, by omission, they failed to prepare. This would be unjust. However, society, institutions, and health care workers would fail in their duty to patients if care is not provided.

---

[24]Lisa C. McCormick et al., "Mississippi Medical Reserve Corps: Moving Mississippi from emergency planning to response ready," *Journal of Public Health Management and Practice* 23.1 (January–February 2017): 47–53, doi: 10.1097/PHH.0000000000000451; and Lainie Rutkow et al., "Perceived facilitators and barriers to local health department workers' participation in infectious disease emergency responses," *Journal of Public Health Management and Practice* 23. 6 (November–December 2017): 644–650, doi: 10.1097/PHH.0000000000000574.

[25]Adhikari et al., "Epidemiology," 1–12; and Singhal, "Review of COVID-19," 281–286.

*Individuals with High Risk*

A wide range of characteristics have been associated with increased risk of COVID-19, including age, poor immune function, recent surgery, hypertension, heart disease, diabetes, and Parkinson's disease.[26] Peking Union Medical College Hospital developed helpful guidelines for exempting health care providers with the following conditions from front-line response: "pregnancy, age over 55 years old, a past history of chronic diseases such as chronic hepatitis, renal diseases, diabetes mellitus, autoimmune diseases and tumours."[27] These and similar considerations also apply to health care providers' family members.

**Duty to Care during COVID-19**

Ultimately, this is a prudential decision, and it must be based on the unique circumstances of the agent in addition to the considerations discussed here. It is probable that some health care workers in either category can with good conscience refrain from activating during an emergency. Nevertheless, as mentioned above, the health care profession is a unique manifestation of eternal vocation, and it transcends transactional, satisfying, or rewarding employment.

A prudential decision to not activate for care on the front lines of the pandemic might not be immoral. However, if health care workers decide to follow this course of

[26]Adhikari et al., "Epidemiology," 1–12.
[27]Li, "Diagnosis and Clinical Management," 582–585

action—that is, if they are unable to fulfill their duty to care, as required by the right to life—they should discern carefully if they are in the correct profession or, at least, in the most appropriate role. As Aquinas point out, "For a diversity of actions requires a diversity of men appointed to them, in order that all things may be accomplished without delay or confusion. … 'As in one body we have many members, but all the members have not the same office.'"[28]

It would be a grave injustice for health care workers to place the community at risk by implying that they can fulfill a duty they cannot, especially once this has become clear. Nevertheless, those who decide not to activate on the front lines remain professionally responsible for offering vocational skills in the "diversity of action" of medicine by finding creative ways to contribute to quality, safety, and education initiatives. These could include education for health care works and the public, telehealth services and other alternative modalities of care, gathering and distributing personal protective equipment, and implementing an attitude of support, faith, prayer, and encouragement.

---

[28]Aquinas, *ST* II-II.183.2 corpus.