What healthcare professionals owe us: why their duty to treat during a pandemic is contingent on personal protective equipment (PPE)

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ABSTRACT
Healthcare professionals’ capacity to protect themselves, while caring for infected patients during an infectious disease pandemic, depends on their ability to practise universal precautions. In turn, universal precautions rely on the availability of personal protective equipment (PPE). During the SARS-CoV2 outbreak many healthcare workers across the globe have been reluctant to provide patient care because crucial PPE components are in short supply. The lack of such equipment during the pandemic was not a result of careful resource allocation decisions in the global north, where the short supply could be explained through their high cost. Instead, they were the result of democratically elected governments prioritising low tax regimes over an adequate resourcing of their healthcare delivery systems. Such decisions were made despite global health experts warning about the high probability of pandemics like SARS-CoV2 occurring during our lifetimes. Avoidable allocation decisions by democratically elected political leaders resulted in a lack of sufficient PPE for healthcare professionals. After discussing and discounting various ethical arguments in support of a professional obligation to treat, even without or with suboptimal PPE, I conclude that these policy decisions were sufficiently grave that they provide a sound ethical rationale to justify healthcare workers’ refusal to provide care to infected patients.

INTRODUCTION
During the SARS-CoV2 pandemic many doctors and nurses have been reluctant to provide care to COVID-19 patients. The UK’s doctors’ leaders have warned repeatedly that the lack of appropriate PPE puts doctors’ lives at risk.1 PPE levels in Australia’s state of Queensland were very low, noted the state’s Clinical Senate Chair Alex Markwell.2 Bulgaria has seen a wave of doctors and nurses resigning at two hospitals in the country’s capital3 over the lack of access to PPE, Zimbabwean doctors and nurses have reportedly gone on strike over the lack of protective equipment,4 and nurses across the USA have reportedly gone on strike over the lack of PPE,5 and nurses across the globe have been reluctant to provide patient care because crucial PPE components are in short supply.6 Many more have fallen very seriously sick.6

In response to concerns about the availability of personal protective equipment (PPE), during the SARS-CoV2 outbreak many healthcare workers across the globe have been reluctant to provide patient care because crucial PPE components are in short supply. The lack of such equipment during the pandemic was not a result of careful resource allocation decisions in the global north, where the short supply could be explained through their high cost. Instead, they were the result of democratically elected governments prioritising low tax regimes over an adequate resourcing of their healthcare delivery systems. Such decisions were made despite global health experts warning about the high probability of pandemics like SARS-CoV2 occurring during our lifetimes. Avoidable allocation decisions by democratically elected political leaders resulted in a lack of sufficient PPE for healthcare professionals. After discussing and discounting various ethical arguments in support of a professional obligation to treat, even without or with suboptimal PPE, I conclude that these policy decisions were sufficiently grave that they provide a sound ethical rationale to justify healthcare workers’ refusal to provide care to infected patients.

What healthcare professionals owe us
What is it then that healthcare professionals owe us in a crisis like the current one? As patients we...
depend on doctors and nurses to provide professional care to us, because they have the specialist training, and they have a monopoly on the provision of these kinds of services. It is not as if we could turn around and go elsewhere if the hospital’s intensive care unit has an insufficient number of healthcare workers on call.

Most doctors in their graduation ceremonies take a public oath to serve the public good, oftentimes modelled on the World Medical Association’s Declaration of Geneva.12 The Declaration is arguably a modern-day Hippocratic Oath. Until the 1994 version of that influential document, doctors promised to provide emergency care, without any ifs, ands or buts. However, that promise has not been repeated in subsequent iterations of that document,13 so that approach does not address the question at hand. Perhaps the world’s doctors woke up to the dangers of making promises they did not realistically intend to live up to. What do the traditions of the medical profession look like then? As Ariel R Schwartz notes, ‘the history of medical ethics reveals that the medical community has never come to a consensus on the nature and scope of its responsibilities during an epidemic’.14 His description of the behaviour of doctors during infectious disease outbreaks from the black plague in the 14th and 15th centuries to the bubonic plague in the 17th century suggests a deeply individualistic response. Many ran away to protect themselves; others stayed behind to care for their patients. The same pattern of behaviour held true during the 2014-16 Ebola virus disease outbreaks in West African countries.

Neither the history of how healthcare professionals responded in the past to pandemic outbreaks, nor their professed values, provide us with much guidance on what the professionals themselves take to be their professional obligations. In any case, why would anyone want to leave decisions on what the profession and its members owe to society to the profession?15 We have little reason to assume that it won’t look after its members first. Medical associations, unlike statutory regulatory bodies, despite protestations to the contrary, are essentially glorified trade unions representing their members’ interests. This situation would not be the first where such associations might prioritise their members’ interests over the good of society.16

One could reasonably argue that there is an implied voluntary consent to risk-taking when healthcare workers accepted the deal their profession cut with society. Monopoly powers, high societal standing and, at least for medical doctors, oftentimes high salaries do not come without a price. Healthcare professionals knew, if they paid attention to the subject in their global health classes, that infections such as severe acute respiratory syndrome (SARS), Middle East respiratory syndrome (MERS), Ebola and others were going to raise their ugly heads during their lifetime, and joining the profession meant accepting a duty to provide care. During the early days of the HIV pandemic, when an infection with that virus meant certain death, regulatory bodies in most countries eventually decreed that healthcare professionals had an obligation to treat.14 Given COVID-19’s much lower mortality risk, this should settle it, or so one might think. That is a mistaken view.

What makes SARS-CoV2 different is that the HIV response was predicated on the availability of PPE to healthcare professionals. In such a reality, if healthcare professionals followed universal precautions and had the right protective equipment, the odds of them picking up HIV would have been negligible. With SARS-CoV2 we are, in most countries, in a very different situation.

**NEOLIBERALISM AND THE FETISHISATION OF ‘EFFICIENCY’**

One feature closely linked to the functioning of global capitalism is efficiency. Everybody involved in the value chain aims to avoid the waste of money and resources. There is a virtue in running ‘lean’ operations. Most countries in the global north, that operate varieties of public or publicly funded healthcare systems, saw the re-election of cost-cutting governments who ran successfully on election campaign platforms promising to ‘return money to our back pockets’ and away from big government.17 This claim certainly is an uncontroversial one for governments elected in countries like the UK, France, Germany, and Australia, to name just a few, during the last few decades. And as taxpayers we did get money returned to our back pockets by low tax regimes. As neoliberal election campaign lore has it, we know best how to spend our hard-earned money. Such policies were anything but cost neutral, as those in need of public services have known for a long time. They succeeded in hollowing out the healthcare delivery infrastructures in most countries. The literature providing evidence to this effect is vast, and it is impossible to do justice here.18 We have little reason to assume that it won’t look after its members first. Medical associations, unlike statutory regulatory bodies, despite protestations to the contrary, are essentially glorified trade unions representing their members’ interests. This situation would not be the first where such associations might prioritise their members’ interests over the good of society.

The endpoint was the same: democratically elected governments across the global north have left hospitals woefully unprepared for the onslaught of patients, not only in terms of ICU beds and ventilators, but also in terms of PPE. The latter is what matters when we ask ethical questions about healthcare workers’ responsibilities during pandemic outbreaks. The unavailability of PPE to efficiently maintain universal precautions while on the job was a foreseeable consequence of the race to the public services bottom that globalisation motivates.

If the lack of available PPE for frontline healthcare professionals would have been due to a natural occurrence, one could reasonably argue that they should be prepared to accept a certain higher degree of risk. The argument in support of such a view could take recourse to the already-mentioned voluntary informed consent argument. Healthcare professionals signed voluntarily contracts with society to provide reliable services, not only when the sun is shining, but also in times of crisis. If there were a situation where, despite society’s best efforts at ensuring the protection of its healthcare workers against acquiring life-threatening infections while on the job, their risk would remain high, one could argue that they ought to accept a certain degree of risk. They knew there was a chance such an outbreak could occur during their lifetime, and part of the deal with society was that they could refuse the provision of professional care. However, there clearly have to be some limits to such a duty. For instance, society cannot afford to lose a very large number of
its healthcare workers during a pandemic, because the time will come when the pandemic wave has passed, and doctors will still be needed. It would also be unrealistic to expect doctors to risk their lives if there were a high probability of death, say because the best societal effort at resourcing their protection was still insufficient to protect the workers. Surely then their continuing provision of professional services would constitute a supererogatory kind of action.

In any case, these kinds of arguments have been discussed in the literature for a long time. Whatever one makes of these arguments has no bearing on the current situation. The reason for this is that in the current situation the lack of PPE is truly deliberate, it is by human, cost-cutting design. It is not as if governments and their experts did not know that the occurrence of an agent like SARS-CoV2 or worse was likely. For a specialist audience the US Centers for Disease Control and Prevention issued in 2017 community mitigation guidelines.2 4In fact, during former President George W Bush’s presidency the country went to significant lengths in its global pandemic planning.2 4 Even lay people were able to read up on the issue, in a multitude of media. Understanding the likelihood of something like this to occur during our lifetime did not require a great deal of specialist knowledge.2 4Given all this, it was quite a remarkable sight to see on global news programmes the UK Chancellor and Prime Minister standing outside 10 Downing Street, wildly applauding their country’s healthcare professionals’ heroism.2 4 The heroism that they were celebrating, however, was a direct, avoidable consequence of their own government’s austerity policies. An adequately resourced NHS would not have required a significant degree of beyond-the-call-of-duty heroism by healthcare professionals. I should note that I am not making an argument here about the rights and wrongs of resourcing healthcare systems with large numbers of ICU beds, ventilators and other equipment, just in case they might be needed as a result of a new virus making its way through a population. That obviously would require a very significant outlay in terms of resources, and it is unclear to me whether that would indeed be a sound way to spend finite healthcare resources. However, PPE does not constitute hi-tech expensive equipment; all of it can be produced relatively cheaply, and it can be stored in large quantities without taxing a given healthcare system unreasonably financially. That at least seems an uncontroversial claim for any country of the global north. The much vaunted N95 respirator—that probably every country on the globe can be stored in large quantities without taxing a given healthcare system sufficiently of resources to permit them to do their job safely or with minimal increases to their average on-the-job risk. Elections have consequences.

CONCLUSION
We should be grateful to any healthcare professional willing to care for COVID-19 patients, in the absence of professional-standard PPE, but we have no reason to take for granted that there will be one when needed. No healthcare professional can be expected to accept a higher-than-usual degree of risk to their own well-being, simply because we chose not to provide them with the necessary equipment to protect themselves efficiently.

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