Case 1: Treatment Eligibility

Key words: infectious disease; humanitarian mission; Medical Rules of Eligibility; dual obligations; distributive justice; defining a healthcare worker in non-UK context

1. You are a military doctor in charge of a small Ebola treatment unit (ETU) during a major Ebola outbreak in a low-income country. The ETU was established to guarantee that affected healthcare workers would get care. It is believed that this measure will instil confidence in both the local and international communities, so that personnel continue to work or will come to the affected area to help care for the sick and contain the spread of the disease. The recently opened Unit is staffed by military healthcare workers and currently has one Ebola infected patient (about to be evacuated) and two patients potentially infected with Ebola (which may or may not be confirmed).

You are contacted by a local Ebola treatment facility (LETF) and asked to admit a 16 year-old woman with confirmed Ebola. She is the sole surviving member of her family. She has nursed each family member, starting with her mother (a nurse who is believed to have contracted the virus whilst treating patients in the LETF) then her younger siblings and finally her father. The worker at the local unit believes the daughter of his deceased colleague will survive if she can be given intravenous fluids – not an option available in his local unit. You would like to admit this patient. Your reasons are that staff in the unit need to begin to implement and 'test' their practices and policies. Moreover, the local worker has a great deal of experience and his judgement that this patient has a good chance of survival you believe to be reliable.

It will also be a good opportunity to build up trust with the local community. Another member of ETU staff disagrees, arguing that admitting this patient would create a precedent for admitting other non-eligible patients. This would also undermine the mission which retains 'ring-fenced beds' solely for healthcare workers.

The Medical Rules of Eligibility afford some (limited) discretion to admit those who are not ***automatically*** eligible but your colleague has made a valid point nonetheless. There is also the balance of risks to staff to consider.

Issues raised by the case

1. Adhering to the Medical Rules of Eligibility (MRoE)

2. Dual obligations conflict

3. Maintaining the integrity of the mission (can be argued both ways)

4. Fairness and levelling down

Potential learning outcomes

The participant should be able to:

1. Identify and consider broad ethical issues in context

2. Recognise and manage moral distress and professional conflict

3. Increase their understanding of ethical issues surrounding MRoE and relationship with dual obligations conflict

4. Begin to understand and apply consequentialist methods of addressing issues and associated problems

5. Recognise how broad ethical issues may be anticipated and avoided

Tutor notes/self-directed learning suggestions

This case is really designed to look at the application of MRoE when there is reason as well as capacity to admit and treat non-eligible patients. The non-eligible patient is a legal minor in the UK, but at 16 years old has capacity to consent for treatment. We do not know whether she is conscious. Nor do we know how vulnerable she might be, given that all of her immediate family is dead – we do not know what will happen to her on discharge, for instance. These issues might be raised/occur to you but are at a tangent to the learning outcomes for this session and will be explored elsewhere.

If this exercise is being done in a bigger group, consider running it as a role play with different members of the group taking the perspective of one of the individuals described by the case. Through the role play, you might identify various interests and positions available in response to these.

Questions to consider and potential issues that may arise in response to these.

In an advanced group you might start with an open question such as 'What are the issues raised by this case? Who are the main stakeholders or what are their competing interests?'. This will encourage the participants to develop the ability to identify and work through issues systematically for themselves. Otherwise, the following questions may help to raise relevant issues for the group to discuss. Some of the potential positions that the questions may suggest are listed below. These are unlikely to be exhaustive. Try to encourage the participants to come up with positions for themselves, but you may like to prompt any issues that are not mentioned in the discussion as it progresses. There is some overlap between the questions, so if issues are not raised in one place they may arise naturally elsewhere.

1. Is it justifiable to take a patient ineligible under the MRoE in order to determine whether the practices and policies of the new unit are sound?

- *It is never justifiable to instrumentalise a patient (i.e. use as a means to an end). Treatment should be offered only because it serves the best interests of the patient.*

- *It is not justifiable to admit an ineligible patient out with the MRoE because these rules are in place for good reasons. Defying these rules will open up many other possibilities for exceptions that will ultimately harm the stability of the working environment and affect the integrity of the mission (both from the perspective of the chain of command as well as the local community who will realise/think that rules are flexible).*
- *It is justifiable to admit this patient because it will be for her benefit as well as contributing towards the preparedness of staff. She will get better treatment as a result. It would be incorrect, therefore, to think of this example on the model of conducting research, even though it will ultimately benefit a number of other future patients by improving the practices and processes of care in the ETU.*
- *It is justifiable to admit the patient, but only based on the fact that we can help her. There is a line of thought in Western medicine that we have a moral duty to provide care if we have the capacity to do so. It would also alleviate the healthcare workers' moral distress of having empty beds under the MRoE.*

2. Should the patient be regarded as a healthcare worker given that she contracted the virus by caring for her family? What are the problems around defining a healthcare worker in this context? Should the daughter be treated on the grounds that her mother was a nurse who was infected because she continued to work with Ebola patients? Should she be regarded as a health care worker, given that she contracted the virus while caring for infected family members?

- *She did care for her family and thus, by definition, performed health care work. Carers do not have to be 'qualified' carers, e.g. all mothers of new-born infants are de facto carers.*
- *She might even have been taught some aspects of the professional treatment of Ebola patients by her mother. Would this be sufficient to regard her as a health care worker?*
- *Caring for family members may not fall under the ambit of health care work or make one a qualified healthcare worker. This would require one to be professionally qualified AND working in a professional capacity treating any affected individuals and not just restricted to family members. A duty to care for your family is a social norm (some might even think we are **obliged** to care for family members); however health care workers do more than that. Healthcare workers offer care impartially to all patients. In this context healthcare workers offered help impartially in the knowledge that they would be helping infected strangers rather than those they love. Does this morally preclude her from being categorised as a health care worker?*

The problems of defining "a health care worker" in this context:

- *It would be difficult to ask for proof of formal qualifications, and even if you were provided with credentials, you probably could not check their validity.*
- *Volunteers who worked in LETFs may have done so without a formal health care education but nevertheless they have then worked in a "health care system" and would be generally be understood to be healthcare workers.*
- *Volunteers or local health care workers may have received their education from NGOs and therefore may not have any formal/official education as a health care worker. They may nonetheless have been performing many of the same duties.*
- *Can informal care situations (like the one described in this case) be defined by formal criteria?*
- *Risky and vital work (especially in an Ebola outbreak) may be carried out by local people, without whose contribution treating the sick and containing the outbreak would be made considerably more difficult. Examples might include: unqualified healthcare assistants, medical or nursing students, those who dispose of the bodies of people who have died or infected clinical waste, also those who collect and deliver affected patients. Should all such 'frontline' staff be regarded as healthcare workers? Where is the frontline? How should one's contribution to the frontline be verified to prevent others from claiming eligibility?*

Should she be treated because her mother was a health care worker?

- *The simple fact that her mother was a health care worker does not make the daughter a health care worker too (the daughter of a terrorist should not be regarded as a terrorist by family association). Thus, according to the MRoE she does not fall among the eligible population.*
- *The fact that her mother has risked her life (and that of her family?) by her work as a health care worker may result in a moral obligation to the mother to care for her child and thus accept the girl as a patient. Ebola treatment by proxy of eligibility?*
- *If the idea of the mission is to keep the (local) health care system running and to motivate people to keep on working in dangerous conditions, this can be achieved on the one hand by offering a treatment guarantee to those who put themselves at risk but, on the other side, also by extending this guarantee to other family members who may be at a higher risk due to the work of their family member health care workers. Some health care workers may be more concerned about bringing the infection home than they are about being infected themselves.*
- *However, if the treatment guarantee is extended to health care workers' family members and, at the same time, the concept of a health care worker is understood in a broad way, the MRoE may become practically ineffective.*

3. Could the ethical issues in this case have been avoided by offering a single standard of care regardless of status (i.e. beds guaranteed for health care workers but at the same level of care offered locally)?

It could be argued that this ethical issue would be avoided if the putative patient had access to the same care locally as that available in this unit – there would be no advantage to her being treated here as opposed to in the local facility. Thus, health care workers would be guaranteed a bed but not a better standard of care. This question is designed to get students to consider the pros and cons of this potential 'solution'. We might expect the following issues to be discussed:

- *Do the UK military have to offer a similar/same standard of care that would be available in the UK to eligible patients?*
- *It is difficult for health care workers trained to provide all possible care to patients to be ordered not to, but maybe an occupational hazard when working in a military or humanitarian context.*
- *Offering 'gold standard' care might be necessary to provide reassurance to international workers from countries accustomed to a highly developed health service. They may not feel that the risk associated with deployment is acceptable if the standard of care available will be only equivalent to that of the local population.*
- *There might be greater solidarity with local patients and health care workers if everyone is given the same treatment. Is it important that health care workers who are infected are treated but not that they get 'better' treatment than their own patients received?*
- *If it is possible to improve the prospects of survival of health care workers this is a good thing, as each health care worker might be in a position to save more lives in future as a result of surviving. Maximising their chances of survival improves the chances of survival of future affected individuals in the local population. This is in accordance with the rationale of the mission. A surviving healthcare worker is potentially an optimal worker as they may have some limited immunity from further infection (assuming they are willing and able to resume working with Ebola patients).*
- *The Oslo guidelines (https://www.unocha.org/sites/unocha/files/OSLO%20Guidelines%20Rev%201.1%20-%20Nov%2007_0.pdf)require humanitarian organisations, including military ones, not to undermine local services. Does providing a higher standard of care undermine local services? To what extent do the MRoE serve to ensure that the Oslo guidelines are followed?*

4. If this patient is refused admission what effect might it have on the trust built up with the local community?

This question picks up on the existing relationship that the military doctor has with the local health care worker/s. Good relations might also be key to the success of the mission. The following issues might be raised:

- *The local worker might also be trying to determine how good this facility really is. Obviously the mission will only succeed in reassuring health care workers if they believe that they will receive effective care if they travel to this facility.*
- *It is important to build up relationships with local workers. It is natural that these health care workers will assume a certain level of cooperation from fellow professionals. The local worker also has a duty of care to do the best for his patient and believes that his patient's best chance of survival is admission to this unit – potentially he has to try. The issue is whether the military facility can/should help. It may be worth 'bending the rules' in this case to build up/continue trust. But how far can one go in this respect? What might the limits be in terms of numbers/types of patient?*
- *Would accepting this patient set a dangerous precedent? Will the military facility become nothing more than an overflow facility for the local ETF? Is it the ETU's responsibility to manage the host nation's clinical needs? Where should we draw the line?*
- *It may be important to build trust with local health care workers to enforce the MRoE – i.e. to demonstrate that the Commander is determined to ensure that beds are available for health care workers and will not be swayed by the overwhelming needs/ claims of other patients.*

5. Consider the ways in which admitting this patient may preserve the mission and the ways in which it may threaten the mission. Is it acceptable to ignore MRoE when there is availability?

- *The MRoE have been devised to help those on the ground to deliver the mission effectively and prevent 'mission creep'. They provide military healthcare workers with a legitimate reason to refuse admission. If exceptions are made in one case it will be difficult to refuse admission to other patients in need without appearing to have an arbitrary admission policy. The mission may be endangered if the beds are fully occupied by non-eligible patients when a health care worker needs treatment for Ebola. The doctor may then have to empty a bed of a patient to whom there will then be an existing duty of care or refuse entry to the health care worker. Discharging an infected patient would be difficult – where would s/he go and how would s/he get there? Alternatively, if the health care worker is refused admission word will spread and the integrity of the mission may be undermined.*
- *The integrity of the mission will be endangered if the local community become aware of the empty beds inside and under-employed specialist staff available.*

Appearing to ignore the needs of the community may create a hostile environment, leading to conflict, with potential additional risks for the staff, patients and the angry population, and ultimately the mission may be withdrawn.

- *Given this is a humanitarian mission there may be a mismatch between the MRoE (that might be appropriate for conflict zone) and the mission*
- *There is also the integrity of the staff itself - how they perceive the breaking or adhering to the rules will affect their morale/levels of moral distress.*
- *The staff need to treat affected patients to maintain their levels of skill and constantly put their training into practice (e.g. in relation to PPE and other infection control measures). Thus, maintaining a constant level of bed occupancy will ensure that the unit delivers the mission more effectively and safely.*
- *The staff working in this unit are also protected by the MRoE since they are all health care workers. They may not collectively be willing to work at capacity if this means that should they become infected they may not get treatment.*

6. Would it be right/wrong to refuse admission to this patient because you couldn't offer the same care to other patients in her position?

This question ensures consideration of fairness (distributive justice) and selective exclusion.

- *On the one hand it seems right that all patients should be treated equally. There may be other equally 'deserving' patients in the local facility (or indeed who are unable to get a bed there) who could also benefit from admission but whose case the local doctors has not chosen to highlight. It is not fair on them for this patient to benefit when they cannot.*
- *On the other hand, to refuse her on these grounds seems to be a case of 'levelling down'. Usually we would say that we should achieve equality by 'levelling up' and giving the benefit to all – but that is not always possible.*
- *We might therefore think that if we can't save all it is better to try to save those who we can – even though all the others are equally deserving of being saved. It would be wrong not to save the one/few if one could. But there still is a question as to whether THIS patient is the most deserving of all possible patients vs lottery. But in cases where there is overwhelming need it may be wasting time and resources to try to select patients using anything other than basic triage principles.*
- *We might also consider what is owed to those who have been 'promised' care (the health care workers), e.g. 'first come, first served.' Even if we disagree that they are somehow more deserving (which we may or may not) it may still be wrong to go back on our promise to give this care even if our services could be more effectively employed treating another patient.*

7. **Given that this patient falls outside the MRoE is it wrong to ask the staff to run the infection risks involved with treating this patient? What about the risks associated with insubordination*?***

- *Military personnel deploy as a result of orders. Those issuing the orders have a duty to ensure that the risks to those following them are minimal / justified. In this case the risk assessment for the mission will have been influenced by the MRoE, which should themselves have been influenced by what is necessary to achieve the mission. Treating non-eligible infected patients could therefore be regarded as taking an unnecessary risk. This risk is taken by the admitting doctor for all involved staff not just her/himself.*
- *The risks are the same whoever is treated and are minimal if safety procedures are followed.*
- *Doctors and other healthcare professionals have a duty to care for patients even at some risks to themselves. But how much and what kinds of risks?*
- *Is having to live with MRoE within a chain of command something that health care workers accept, and therefore have to 'suck up' when joining the military? Do they therefore also accept the risks of moral distress that this may generate in practice? Can they leave if they don't like it?*