Case 6: Risk avoiding colleague in an infectious disease setting

Key words: duty to take risks; providing care in risky situations; human factors; fairness; nature of humanitarian intervention

You are a military healthcare professional, working in a temporary facility in a low-income country as part of the international humanitarian response to a viral disease outbreak. High quality personal protective equipment is available, but no vaccination is yet available to protect against this particular virus. You begin to realise that one of your colleagues is avoiding providing direct clinical care to affected patients. This means that they are actively avoiding entering areas where infectious patients are being treated. When they do go in, they avoid performing any procedures that put them at greater risk of infection (such as touching the patient, attending to hygiene needs, taking blood, giving drugs or certifying death etc.). You begin to feel resentful as this means that this person's colleagues have to pick up the slack in the workload – which basically means more unpleasant work for each of them, and being exposed to risk more often. You mention this to another colleague, who shrugs and says that everyone has to decide for him or herself what risks they are prepared to take. They also comment that the seemingly risk-avoiding colleague has children and you don't, and that you volunteered for this mission but others didn't. Some people just don't agree that the military should be doing this kind of humanitarian deployment, and 'didn't sign up' for this kind of risk when they joined the Armed Forces.

Issues raised by the case

1. Duty of honesty and candour. (Where? To whom? Will being honest about their feelings have any bearing on the deployment / situation?)

2. Team working and dynamics. (Human factors.)

3. Balancing the priorities of patient care and reducing risk of infection.

4. Difference between military facilities and those run by NGOs

Potential learning outcomes

1. Identification and consideration of the pertinent ethical issues.

2. Coping with team working and dynamics in difficult situations.

4. Beginning to understand and apply consequentialist ways of addressing issues and associated problems (or at least understanding the difficulties in applying a deontological approach in certain situations.)

5. Beginning to understand how ethical issues may be anticipated and avoided.

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1. How would you define the obligations of a humanitarian worker in meeting the requirements of care of the affected victims?

Humanitarian assistance is generally accepted to mean the aid and action designed to save lives, alleviate suffering and maintain and protect human dignity during and in the aftermath of crises resulting from human behaviours (war, conflict, famine) and natural disasters (flooding, earthquakes). Assistance may also be given to prevent and strengthen preparedness for the occurrence of such situations (Source: Good Humanitarian Donorship).

What marks it out from other forms of aid and foreign assistance is that it should be guided by the humanitarian principles of:

- *humanity – saving human lives and alleviating suffering wherever it is found.*
- *impartiality – acting solely on the basis of need, without discrimination between or within affected populations.*
- *neutrality – acting without favouring any side in an armed conflict or other dispute where such action is carried out.*
- *independence – the autonomy of humanitarian objectives from the political, economic, military or other objectives that any actor may hold with regard to areas where humanitarian action is being implemented.*

(Source: https://docs.unocha.org/sites/dms/Documents/OOM-humanitarianprinciples_eng_June12.pdf)

Additionally, in contexts such as these we might add that whilst treating patients with compassion, care, humanity and meeting their clinical and nursing needs, workers also owe a duty to protect themselves (and colleagues) against risk of infection as far as is practicable.

2. Are the requirements different if you are deployed as part of a military treatment facility? If so, how? Identify the areas of potential ethical conflict between being an NGO humanitarian healthcare worker and a military healthcare professional.

Members of the military swear an oath and have a duty to obey orders. This may conflict with their role as a humanitarian healthcare worker. For example, if the military withdraws from a situation personnel cannot continue delivering humanitarian assistance, they must follow orders.

If we look at the criteria of a humanitarian worker we can see direct conflict on a number of issues:

- *Humanity – saving human lives and alleviating suffering wherever it is found: military deployed medical facilities usually have very strict eligibility criteria for*

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admission and treatment (the Medical Rules of Eligibility, or MRoE). But NGOs also have to work within the confines of their mission brief and negotiations for access. All humanitarian relief should adhere to the Oslo guidelines, which may also be regarded as setting a ceiling on the aid made available.

- *Impartiality – acting solely on the basis of need, without discrimination between or within affected populations. 'Eligibility for treatment' criteria may mean that some potential patients are turned away. On combat missions, reserving capacity for wounded soldiers is often given priority over offering treatment to local populations. MRoE exist in every deployment of a military treatment facility. The criteria for accepting patients is usually set at a high political level; but the Medical Director of the facility will normally have limited discretion to work outside these MRoE depending on local circumstances. On the other hand, if someone is accepted as a patient, one would then expect treatment to be provided impartially on the basis of need and urgency. A wounded enemy combatant should not be treated differently to a wounded comrade, for instance, and in an epidemic an affected local healthcare worker should have the same status as an infected UK national NGO worker .*
- *Neutrality – acting without favouring any side in an armed conflict or other dispute where such action is carried out. Military medical treatment facilities, especially in combat situations, cannot be neutral. This is because they will have been invited into the country by the host nation government, or will have been ordered into a country by their government as part of an occupying force. Either way they will already have been tacitly deemed to have 'taken sides' in, for instance, civil conflict. Being invited in to help with natural disasters may not have the connotations. Nonetheless, governments decide upon which events to response to and how, and they may be driven by considerations that go beyond the purely humanitarian (commercial, political etc). Some NGOs find it very difficult to remain completely neutral. MSF, for instance, will criticise parties in a conflict. It is sometimes felt that remaining neutral can perpetuate injustices that lie at the heart of some disasters.*

  > *"If an elephant is standing on a mouse's tail and you refuse to urge the elephant to move, the mouse could be forgiven for thinking that you are on the side of the elephant." Desmond Tutu*

- *Independence – the autonomy of humanitarian objectives from the political, economic, military or other objectives that any actor may hold with regard to areas where humanitarian action is being implemented. In this case, military treatment facilities cannot be truly independent of such concerns; as individual military healthcare professionals will likely be subject to orders that likely have political, economic and military origins / motives / objectives.*

Whether or not this means that there are some kinds of risks that military personnel can refuse to take, however, remains a moot point. It is not clear whether, for instance, objecting that the military cannot be humanitarians would count as a justification for risk aversion in a case such as this one.

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3. How do you judge what risks you should take, or be exposed to, whilst performing clinical tasks?

This will be based partly on common practice, professional guidelines, your role and area of expertise. Professional codes of conduct have changed in this regard over the years from suggesting that the taking of risk is part of the duty of healthcare professionals, to leaving it up to individuals to decide for themselves. At the same time, these codes often add the rider that professionals need to ensure that patients are still being cared for. It is sometimes difficult to see how it is possible for both of these conditions – allowing personal judgement and ensuring patient care – can be met. It is possible that the assumption is that in an environment where the risk can be controlled (e.g. with use of PPE) sufficient numbers of professionals will be willing to take (limited) risks such that services can be provided without patients being abandoned, even though some individual for whatever reason decide that the residual risk is too great for them to take. It is not clear what, therefore, should happen if everyone in a given situation was equally risk adverse (for whatever reason – but let's suppose for the sake of argument that there was a good reason: a risk has been identified but it is not clear how or whether it is possible to minimise it or the institutional structures have broken down or cannot provide the means necessary to minimise the risk). Moreover, permitting individuals to be risk-adverse increases the residual risks for co-workers – they are increasingly exposed to risk-prone procedures, for example. The situation for military workers is further complicated by the implication that a general consent to take risk was understood and agreed to at the time of joining. A risk assessment for missions is made on behalf of individuals by governments and through the chain of command and mitigated with training. Individuals at greater risk (e.g. pregnancy women) may be excluded from certain missions. Thus, it might reasonably be supposed that individuals should accept whatever risks they are asked to accept on the grounds that they would not be asked to take an unnecessary risk (which could be questioned but if justified would have to be accepted). There is an implicit assumption that the order to deploy has contained a judgement about the amount of risk it can reasonably expect individuals to bear balanced against the benefit that setting up the medical treatment facility will have.

4. What are your obligations to other members of the clinical team?

Team members owe each other a duty to care for the welfare of each other, this is both a legal duty enforced by the law of negligence and an ethical consideration. Ethical considerations could be seen to operate both in terms of moral based theory of duties as well as consequences. Some bioethicists refer to these as 'associative / special obligations (Dworkin)', preference ethics (Hare, Singer) or the 'ethics of camraderie' (Gross). Whether in the military or other hierarchies, it is commonly felt that, other things being equal, individuals should not ask others to take risks that they would not themselves be willing to undertake. Indeed, trust may be based on this assumption. But note that this too assumes a certain willingness to substitute another person's judgement for one's own.

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5. In your assigned clinical role, is it a legitimate concern of yours if you believe another team member is failing to perform their role properly? If yes, why is this the case?

Using a consequential type of moral reasoning it may be argued that if one person is failing to perform their role and work-based tasks- it compromises patient care, and the team's effectiveness. Additionally, other team members will become overburdened/ tired/resentful as a result of having to do the extra work, this in turn is likely to lead to mistakes been made and poor patient care. Also, see notes above.

6. How would you raise this issue - with the individual directly, or through line management / chain of command?

You have a moral duty and obligation to your co-workers and employer to be honest. It is always best, and is seen as good practice / management, to attempt to resolve workplace issues at the lowest level first (informally); meaning in this case it would be best to speak to the individual directly. It is also a pragmatic consideration, as you are still going to have to work with this person; and it would probably be counter-productive if you are seen to be going behind their back. Both they and other co-workers are unlikely to trust you if they find that you were not 'up-front' and forthright with the worker who is failing to perform all of their tasks.

In principle, you owe both an ethical and legal contractual duty to your employer through the chain of command to inform them of what is occurring. (But think of the case of NGO workers – what happens when nobody is getting paid and no contractual obligations exist (i.e. voluntary workers)?)

7. Are team members ethically justified to use personal reasons or circumstances to avoid work, so as to decrease their risk of being infected? If we believe that sometimes personal circumstances should affect work distribution and / or risk, which of the following justifications (if any) do you find compelling?

i. **Having children- any, or just young children only?**
ii. **Not having volunteered.**
iii. **Believing that the military should not be doing this kind of deployment.**
iv. **Did not 'sign up' for this type of work when joining the Armed Forces.**

One view point is that an individual who has joined the Armed Forces can be said to have tacitly consented to the inherent and obvious risks of being a part of the military. The argument is that they have then also 'signed up to' and should accept whatever risks are presented to them in the course of performing their military duties. On the other hand, an argument could be made that whilst an individual may accept that being in the military has special risks to their life that are associated with combat; exposing individuals to unusual non-combat risks such as contracting a virulent disease would not be the type of risk a serving member of the military could reasonably expect to encounter. Additionally, it can be argued that individuals owe different moral duties to

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various different people / bodies throughout their lives. Whilst a serving member of the military should be prepared to perform their military role to the best of their abilities, they should also be prepared to perform their roles of parent / carer / friend etc. Where there is conflict between competing roles, some element of compromise should be made; and the military should be flexible in allowing individuals to perform their familial and social roles as well as their military one. Without familial and social support soldiers are less likely to perform their military roles to an optimum level.

8. If the Team Leader ordered the risk-averse individual to perform clinical tasks in the same way as the rest of the team, what might be the consequences?

The rest of the team may feel vindicated, and that some form of justice has been done. It may also reinforce the coherence and sense of identity of the team, as well as cement the team leader's position as an effective leader. However, the chastised member of the team maybe become sullen and resentful, and perform to an even more clinical sub-optimal or risk-averse standard; with the possible consequence of an increased risk of infection to themselves or their team mates. It may however provoke a complete 'shut-down' of the individual, ending in a 'Return to Unit' (being sent home to the UK in disgrace); which means that they cannot necessarily be replaced quickly or easily. This means that the workload will remain just as high as it was, or higher, for the individual's colleagues; but for a potentially longer sustained period leading to sustained higher risk of infection.

The purpose of this question is to encourage learners to find a different solution to the issue.

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