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Health care workers in an epidemy: Roles, rights and duties from a comparative viewpoint

1. Introduction

Irregardless of the advances in medicine, the threat of large-scale epidemies still exists in the modern world. The danger of natural incidence of widespread deadly infectious diseases is amplified by the intercontinental travel and also by the bioterrorism threat. The danger of epidemics is once again shown, as the avian flu spreads step-by-step from Asia to Western countries.[1]

An epidemy is a threat to the whole society, during which the interests of protecting public health may override the protection of individual rights. It is a public duty to prevent and fight epidemies. An important part of this public duty is borne by health care professionals. They are faced by the dangerous task of caring of the diseased and risking their health and lives, and also health and lives of their families whom they may infect. Recent epidemies, such as SARS outbreak, tested the willingness of health care professionals to report to work when a deadly contagious disease emerged. In the time of an epidemy, an effective functioning of the health care system is necessary; due to this, there has been for long an ethical obligation of health care professionals to take this risk and report to work even under such adverse circumstances.

Decisionmakers have to balance individual freedoms against the common good, fear for personal safety against the duty to treat the sick and economic losses against the need to contain the spread of a deadly disease. Some states, such as the Czech Republic, transformed the ethical obligation of

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[1] When I started to work on this issue in Autumn 2005, the rumors were that the avian flu was spotted in several Eastern European countries. This information was later confirmed. The public authorities in several countries reacted with a good deal of panic. For instance, an information leaked from the Slovak Republic Ministry of Health that the public health authorities are searching for suitable sites for mass graves of future pandemic victims, and that World War II manuals were consulted on how to manage such graves, http://www.novinky.cz/zahranicni/70589-slovensko-pry-pripravuje-masove-hroby-pro-pripad-pandemie.html, last accessed on 11/25/2005

health care workers into a strict legal duty; many others did not, keeping the healthcare workers relatively free to decide. In a situation of a grave threat, however, compliance even with a strict legal duty might be insufficient, in spite of the administrative and criminal sanctions. Furthermore, it is unfair to burden a small group, the health care workers, with all the risks and costs of promoting a common good. By offering fair compensation for any risks connected with fighting an epidemy, the governments can improve health care professionals compliance and further spread the burden of pursuing the public interest onto the whole society. The measures of compensation existing at present under the Czech law do not fully encompass all the risks taken, making the compensation insufficient. This Article tries to delimit the the scope of the professionalsґ legal duties that are effective for protection of the society under an epidemy and proposes several ways how to compensate them for the risks they are required to take.

2. Individual rights and liberties in an emergency

Effective management of a public health emergency and mitigation of damages caused by an outbreak of a contagious disease require coordinated effort and public compliance. To counter such emergency, the public health system must detect its outbreak, isolate its victims and organize both preventive and causal treatment of a large number of patients by competent health care workers[2]. As described below, this may be contrary to individual interests of patients who might be unwilling to submit to compulsory treatment, or health care workers who would not want to get in contact with patients infected by unknown agents. If any of such persons were able to apply all their rights and liberties without any limitation, the effective emergency management would not be possible. On the other hand, giving the public authorities an emergency power to override individual rights and liberties is always connected with a risk of abuse, especially when proper safeguards are not present. In this chapter, I briefly examine the general approaches to limitation of individual rights under emergencies, as they are described in the European Convention for the Protection of Human Rights and Fundamental Freedoms, under the Czech Constitutional Law on Emergencies and under the Model State Emergency Health Powers Act.

2.1. European Human Rights Protection

The European Convention for the Protection of Human Rights and Fundamental Freedoms, also known as the Rome Treaty, is one of the most important human rights documents in Europe. It was adopted in 1950 by the Council of Europe. It is a catalogue of fundamental human rights, including right to life, prohibition of forced labour, right to liberty and security, freedom of expression, right to respect for private and family life, right to a fair trial and prohibition of discrimination.

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[2] Wynia, M.K., Gostin, L.O., *«Ethical Challenges in Preparing for Bioterrorism: Barriers Within the Health Care System»*, Government, Politics and Law 2004

The importance of the Rome Treaty is based especially on two of its legal features. Firstly, it has its own enforcement mechanism, which is independent of the national law of the states parties to the treaty. The Rome Treaty establishes the European Court of Human Rights[3], which allows not only member states, but also any individual[4] to submit their claims based on violations of the rights included in the Rome Treaty. The applicant must exhaust all domestic remedies before submitting a claim to the European Court of Human Rights, and the Court has a power to award a just compensation[5] against a state that has violated some of the rights. Due to this, the Court offers an individual a last resort chance of appeal, even against the supreme court of his or her own state. This feature was historically especially important in the case of member states with less developed democratic traditions.

Secondly, the Rome Treaty has an important position in the legal systems of the states that have adopted it. In many of these states, including the Czech Republic, the Slovak Republic and others, this human rights catalogue has a legal power superior to the legal power of most national legislation, with the exception of the Constitutional acts[6].

The Rome Treaty, however, does not place individual freedoms over the public interest, but strikes a careful balance between the protection of individuals and need to protect the society in the case of a threat. The Article 15 of the Rome Treaty describes possible derogations from the individual freedoms in times of emergency. According to this Article, *in time of war or other public emergency threatening the life of the nation any High Contracting Party may take measures derogating from its obligations under this Convention to the extent strictly required by the exigencies of the situation, provided that such measures are not inconsistent with its other obligations under international law*[7]. This exception has, however its limits:

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[3] Article 19 — Establishment of the Court: „To ensure the observance of the engagements undertaken by the High Contracting Parties in the Convention and the Protocols thereto, there shall be set up a European Court of Human Rights, hereinafter referred to as «the Court». It shall function on a permanent basis.“. This Court is usually known and referred to as the Strasbourg Court.

[4] Article 34 — Individual applications: „The Court may receive applications from any person, non-governmental organisation or group of individuals claiming to be the victim of a violation by one of the High Contracting Parties of the rights set forth in the Convention or the protocols thereto. The High Contracting Parties undertake not to hinder in any way the effective exercise of this right.“

[5] Article 41 — Just satisfaction: „If the Court finds that there has been a violation of the Convention or the protocols thereto, and if the internal law of the High Contracting Party concerned allows only partial reparation to be made, the Court shall, if necessary, afford just satisfaction to the injured party.“

[6] Furthermore, the rights described in the Rome Treaty have been taken over to the prepared Constitutional Treaty of the European Union. When this so-called European Constitution gets approved by the EU member states, also these human rights guarantees will have legal precedence over any other legislation on the territory of the European Union.

[7] Article 15 (1) of the Convention for the Protection of Human Rights and Fundamental Freedoms

No derogation from Article 2[8]*, except in respect of deaths resulting from lawful acts of war, or from Articles 3*[9]*, 4 (paragraph 1)*[10] *and 7*[11] *shall be made under this provision*[12]. Furthermore, any derogation from rights has to be notified to the Secretary General of the Council of Europe[13].

The possibility to derogate from the individual freedoms was intended especially for cases of an armed conflict or a grave civilian unrest, which was seen at the time of the creation of this Treaty as a possible problem. The drafters most probably did not have in mind the application of this Article to a situation of emergency caused by a contagious disease. However, the wording of Article 15 does not limit itself to war conflicts, but extends rather broadly also to „other public emergencies threatening the life of nation". Therefore, the derogation could be applied also to disease emergencies, if the extent of an epidemy were great enough to disrupt the functioning of the state and to threaten the lives of the citizens on a large scale. This is even more true if the epidemy were caused by a bioterrorist attack or a series of such attacks, which might be seen as an analogy to a state of war.

Most emergency measures, which are necessary to effectively manage an epidemy and which require a limitation of individual freedoms, would be acceptable under Article 15. Section 2 of Article 15 prohibits derogations from the right to life, prohibition of torture, prohibition of slavery and the rule *nulla poena sine lege*. On the other hand, all other fundamental rights can be limited if it is strictly required by the exigencies of the situation. The public authorities can therefore limit the right to liberty (which may be important for compulsory quarantine and isolation measures), freedom of assembly, the property rights and other freedoms.

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[8] Article 2 — Right to life: „Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law. Deprivation of life shall not be regarded as inflicted in contravention of this Article when it results from the use of force which is no more than absolutely necessary in defence of any person from unlawful violence; in order to effect a lawful arrest or to prevent the escape of a person lawfully detained; or in action lawfully taken for the purpose of quelling a riot or insurrection."

[9] Article 3 — Prohibition of torture: „No one shall be subjected to torture or to inhuman or degrading treatment or punishment."

[10] Article 4 — Prohibition of slavery and forced labour: „1) No one shall be held in slavery or servitude."

[11] Article 7 — No punishment without law: „No one shall be held guilty of any criminal offence on account of any act or omission which did not constitute a criminal offence under national or international law at the time when it was committed. Nor shall a heavier penalty be imposed than the one that was applicable at the time the criminal offence was committed. This Article shall not prejudice the trial and punishment of any person for any act or omission which, at the time when it was committed, was criminal according to the general principles of law recognised by civilised nations."

[12] Article 15 (2) of the Convention for the Protection of Human Rights and Fundamental Freedoms

[13] Article 15 (3) of the Convention for the Protection of Human Rights and Fundamental Freedoms

Under the Rome Treaty, the health care workers are not protected from compulsory provision of medical aid when the public health authorities call upon them in connection with emergency management. Article 4 states in section 2 that *no one shall be required to perform forced or compulsory labour*. However, Article 15 prohibits only derogation from the first section of Article 4, which is the prohibition of slavery, but not the rest. Furthermore, Article 4 describes the term «forced or compulsory labour» as non including, *inter alia*, any service exacted in case of an emergency or calamity threatening the life or well-being of the community. Therefore, under emergency conditions, the health workers cannot invoke the Rome Treaty as a defence to a compulsory labor assignment by a public health authority.

2.2. Czech Constitutional Law on Emergencies

The legal system of the Czech Republic is based on the Civil law tradition. There is a hierarchy of legal norms, according to which the constitutional acts and international treaties have a precedence over „simple" (non-constitutional) acts of parliament. The norms with lesser legal power have to be fully in accordance with the norms with greater power. The fundamental human rights are protected on the constitutional level. Neither „simple" acts of parliament nor any court decisions can therefore limit such rights, unless an exception for such limitation exists at the constitutional level.

The 1993 Charter of Basic Rights and Fundamental Freedoms[14], the constitutional act that lists the most important liberties, is the Czech analogy of the U.S. Bill of Rights. The rights stated in this Charter include the right to personal integrity, freedom of movement, prohibition of discrimination, privacy rights and property rights. The 1998 Law on Security of the Czech Republic is a constitutional act which provides exceptions from the protection of fundamental freedoms and gives the State the necessary authority for times of emergency or threat to the national sovereignty. Because the Charter is a constitutional act, any derogations, according to hierarchy of legal norms, have to be stated also by a constitutional act. The Law on Security states that protection of lives and health is a fundamental duty of the government; however, this constitutional act also states that this duty is borne by all physical and legal persons, including also non-government organizations and all citizens, to an extent described in law[15]. A state of emergency can be declared by the government in case of natural disasters, industrial accidents or other situations that in a considerable extent endanger lives, health or property of citizens, or an internal order and safety[16]. An outbreak of epidemy or a bioerrorist attack can be without any doubt subsumed under the category of „other situations endangering lives".

When time is of essence, the state of emergency can be declared by the prime minister; his decision has to be approved or denied within 24 hours by the government. The maximum lenght of the state of emergency is 30

[14] Act 2/1993 Coll., Charter of Basic Rights and Fundamental Freedoms
[15] Article 3 of the Act 118/1998 Coll. on Security of the Czech Republic
[16] Article 5 ibid.

days. The government immediately informs the Chamber of Representatives about the state of emergency, and the Chamber of Representatives may annul the decision. Only the Parliament can extend the 30days time-limit. The declaration of emergency can be effective immediately and is acknowledged in media. In the declaration of emergency, the government has to specify the reasons, the area for which the emergency is declared and also what fundamental rights will be restricted and what duties will be imposed[17].

The emergency legislation was not yet tested, fortunately, in the contagious disease settings. However, the public authorities have enough legal power to get any help from the persons or organisations who are competent to render it, especially from hospitals and health care workers. The possibility to limit the constitutionally guaranteed property rights in an emergency could theoretically extend to the area of intellectual property and treatment-related patents, if it could reasonably aid efforts to counter the epidemy. The relevant laws[18] include relatively harsh sanctions for non-compliance. The principal question is the compensation; the law does not properly define the compensation amount; in the case of health care workers, I return to this issue later in this article.

2.3. United States and the Model State Emergency State Powers Act

In the United States, the public health has historically been considered primarily the business of the states. The reason is that when the former colonies delegated powers to the federal government in the U.S. Constitution, they retained the authority to protect the public health and safety under the state's police powers.

The anthrax attacks changed the attitude of states. Threat of bioterrorism requires coordinated response. The Center for Disease Control and Prevention (CDC) has advised all states to review the adequacy of their laws, with special attention to provisions for quarantining people in the event of a bioterrorist attack. In addition, the CDC released in October 2001 a proposed model act for the states, the Model State Emergency Health Powers Act, which was later re-drafted. The model act is based on the belief that in

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[17] Article 6 ibid.; For instance, in summer 2002, when over one third of the country including the capital city of Prague was flooded after a heavy rain in the mountain regions caused overflow of the dams on major rivers, the Government issued series of emergency declarations for several regions which followed the teritorial incidence of the flooding. These declarations temporarily limited freedom of movement, inviolability of place of residence, and right to own property17. Due to this, the emergency authorities and the Czech Army were able to effectively evacuate large housing areas and get under control any separated attempts of looting. The overall results were positive. Although the extent of the 2002 flood was considerably greater compared to a similar natural disaster that occured in 1997, before the existence of the emergency legislation, only a very small number of people lost their lives in connection with the flood and, despite large property damage, the help for victims could be organized quickly and effectively.

[18] Act 240/2000 Coll.

public health emergencies, there must be a trade-off between the protection of civil rights and effective public health interventions[19]. There is a precedent for this approach in the 1905 *Jacobson* v. *Massachusetts* case, which involved compulsory vaccination and in which it was held that *„the whole people covenants with each citizen, and each citizen with the whole people, that all shall be governed by certain laws for the common good.*"[20]

In the MSEHPA, public health emergency is defined as *„an occurence of imminent threat of an ilness or health condition that is believed to be bioterrorism the appearance of a novel or previously controlled or eradicated infectious agent or biological toxin...which...poses a high probability of any of the following harms: a large number of deaths, a large number of serious disabilities in the affected population or widespread exposure to a dangerous infection or toxin*[21].

The original version of MSEHPA was made subject to criticism on several grounds. Firstly, it fails to include basic checks and balances. According to the critics, the Act lets a governor declare a state of emergency unilaterally and without judicial oversight, which might cause fears of discriminatory use of the quarantine power against particular groups of people based on race and national origin, for example. The lack of checks and balances could have serious consequences for individuals' freedom, privacy, and equality.[22]

Secondly, it goes well beyond its primary purpose, bioterrorism protection. The act includes an overbroad definition of „public health emergency" that sweeps in HIV, AIDS, and other diseases that clearly do not justify quarantine, forced treatment, or any of the other broad emergency authorities that would be granted under the Act.[23]

Finally, it lacks privacy protections, by requiring the disclosure of massive amounts of personally identifiable health information to public health authorities, without requiring basic privacy protections and fair information practices that could easily be added to the bill without detracting from its effectiveness in quelling an outbreak.[24]

2.4. Conclusion: Civil Liberties and Emergencies

The advantage of the possibility to restrict civil liberties in case of an emergency is that the state authorities can force the compliance of population. This very fact can however turn easily into a disadvantage. In history, there are examples of public emergency declarations that have suspiciously coincided with adverse changes of regime or political oppression. According to Annas[25], the authority to respond to a bioterrorist attack or a new epidemic

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[19] Annas, G.J.: *«Bioterrorism, Public Health, and Civil Liberties»*, The New England Journal of Medicine 2001

[20] Jacobson v. Massachusetts, 197 U.S. 11 (1905).

[21] The Model State Emergency Health Powers Act: as of October 23, 2001, Centers for Disease Control and Prevention, 2001.

[22] ACLU, *„Q&A On the Model State Emergency Health Powers Act"*, 2005 http://www.aclu.org/privacy/medical/14857res20020101.html

[23] Ibid.

[24] Ibid.

[25] Ibid.

under MSEHPA is much too broad, since it applies not just to real emergencies such as a smallpox attack but also to nonemergency conditions as diverse as annual influenza epidemics and the AIDS epidemic. On the other hand, however, the MSEHPA gives the governor enough flexibility to effectively counter the emergency outbreak, while the probability of political abuse of these powers is in an open society relatively low. The European system, in comparison, of emergency legislation offers double protection, on the European and national level. With an immediate parliamentary control, notification procedure to the Council of Europe and limits on scope of emergency measures, the legislation offers emergency powers without creating a danger of abuse.

3. Duties of Health Care Workers

In handling a contagious disease epidemy, the health care system must fulfill three tasks: to detect potential victims, to contain the spreading of the disease by means of quarantine or isolation, and to provide treatment to the sick[26]. Especially the third task, treatment, requires increased effort on the side of health care workers. When an unknown disease starts to kill, there are strong incentives on the side of health care workers to avoid any contact with potentially infected patients. When the health care professionals decide to treat suspected carriers of a deadly disease, they take several categories of risks.

Firstly, there is a risk of endangering the health or life of the health care worker him- or herself. Furthermore, in the case of a contagious disease, the risk of transmitting the disease extends to his or her family members, friends and co-workers of the health care professional. Therefore, although many health care workers might be relatively unaffected by the possibility of infecting themselves, their attitude to taking those risks can differ radically when the decision to report to work affects also their close relatives.[27]

Secondly, there are economic risks. The medical doctors who help the epidemy victims come into real risk of being quarantined or isolated themselves and thereby losing their earning capability. Furthermore, in a

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[26] Similarly in Wynia, M.K., Gostin, L.O., *«Ethical Challenges in Preparing for Bioterrorism: Barriers Within the Health Care System»*, Government, Politics and Law 2004

[27] In a hospital case from Canada, Lucy Smith, a nurse with 17 years' experience who works in St. Michael's Hospital in Toronto at a dialysis unit, rebelled when she was «drafted» into St. Michael's special SARS team. She refused, claiming measures to protect her, and by extension her 3 children and immunocompromised mother, who is recovering after a kidney transplant, were inadequate. «Maybe I could pass something to her,» says Smith. «If it was just myself, I would [join the team]. But can the hospital guarantee that I [won't] get sick, or my kids and mother?» About 100 staff volunteered to be part of the hospital's SARS team, but another 65 were needed. Smith was selected, and says her director implied that her refusal to join the team might lead to dismissal; her union advised her to obey the order. While attending the June 9 orientation meeting, however, Smith announced that she would not join the team. Barbara Sibbald , *„Right to refuse work becomes another SARS issue", CMAJ* July 22, 2003

system, in which the profitability of a health care provider depends to a large extent on private patients, an encounter of a health care facility or some of its employees with an unknown disease victims may cause significant economic losses. The health care facility may get isolated and therefore lose its ability to service the profitable private patients. Or, the private patients, knowing that the health care workers came into contact with the contagious disease victims, may decide to choose another provider to avoid any possible risks of transmitting the disease.

I begin this section with a discussion whether the concern about unwillingness of health care workers has a real basis. Then, I turn to ethical and legal obligation of a health care worker to report to work and provide aid in the contagious disease emergency settings.

3.1. Unwilling Health Care Workers: Is It a Real Problem?

Initial commentators of the emergency legislation claimed, on the basis of experience from the 9/11 attacks and the anthrax attacks, that physicians, nurses, or members of the public are not in fact reluctant to cooperate in the response to a bioterrorist attack or unwilling to take drugs or vaccines recommended by public health or medical officials. Contrary to the fears that physicians might not be willing to provide services in a public health emergency, there was sufficient evidence in the heroic response of emergency rescue and health care workers in the aftermath of 9/11. It is also true that various health care professionals (e.g., emergency department personnel, intensivists, and other "hospitalists") routinely provide dedicated and excellent medical care despite the absence of an ongoing relationship with the patient[28].

The problem is that, in case of deadly highly contagious diseases and unknown risks, the situation might be different. When the SARS epidemy became an issue, these fears have proven true. According to reports, at least one hospital in China had difficulty maintaining services because of absenteeism in the face of SARS. Some hospitals in New York have announced they will not care for victims of bioterror attacks. And relatively few physicians have volunteered to receive smallpox vaccination, despite high-level government requests.[29] SARS was transmitted largely through hospital-based exposures, and thus healthcare providers were disproportionately affected. The percentage of SARS cases involving health care workers ranged from 19% in China to 57% in Vietnam. In Hong Kong, 22% of the deaths were among physicians and nurses, and in Taiwan over 90% of the infections occurred in hospitals.[30] The fear of infection caused substantial numbers of health care workers to refuse to treat SARS patients. For example, in Taiwan, 160 health care workers resigned rather than work on SARS wards. Part of the reluctance to treat people with SARS may be attributable to the lack of adequate protective equipment, but part of it was simply fear of contagion—

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[28] Rothstein, M.A., *„Are Traditional Public Health Strategies Consistent With Contemporary American Values?"* Temple Law Review 2004

[29] Huber, S.J., Wynia, M.K.: *„When Pestilence Prevails…Physician Responsibilities in Epidemics"* The American Journal of Bioethics, 2004

[30] Ibid.

even with protective masks, gloves, and gowns—or concerns about disruption of their lives and social ostracism[31]. The problem might be even more pressing in the United States.[32]

There is a legitimate reason for unwillingness on the part of health professionals. Health care workers were, for instance, common second-wave victims of Ebola and SARS. Both in the United States and Europe, there are documented cases of health care workers becoming infected with HIV due to needle-stick injuries[33], and countless more have contracted hepatitis B or C, tuberculosis, and other potentially deadly infections. Signs of a potential or real unwillingness to provide care or to prepare for that have been already widely reported in media.[34]

Especially in countries that respect the professional authonomy in choosing patients, the problem of reluctance of health care providers to respond to a contagious disease epidemy seems to be real. Other countries however, as has the SARS epidemy shown, are arguably not immune against this problem either, despite strong measures available in their laws to enforce health care workers compliance.

3.2. Ethical Obligation to Provide Care

The legal duties of health care professionals, especially physicians, are historically preceded by ethical obligations, and correct interpretation of legal rules should take medical ethics into account. The relevant rules of ethics include two issues: the duty of a physician towards the society[35] and the freedom of physicians to choose whom to serve.

Classical Greek and Roman physicians were probably unable to formulate a duty to treat potentially contagious patients. While Hippocrates and

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[31] Huber, S.J., Wynia, M.K.: *„When Pestilence Prevails…Physician Responsibilities in Epidemics"* The American Journal of Bioethics, 2004

[32] Rothstein, M.A., *„Are Traditional Public Health Strategies Consistent With Contemporary American Values?"* Temple Law Review 2004; The refusal to care for infected patients might be even more widespread in the United States than in Asia and Canada. During the 1980s and 1990s, many physicians, nurses, dentists, and other health care providers refused to treat patients with HIV, even though the routes of transmission were known and there was much less risk of infection than with SARS. According to Dr. Daniel Bausch of Tulane University's School of Public Health and Tropical Medicine: "If you have an outbreak of, say, Ebola, most of the medical staff heads for the hills."

[33] *Prevention of needlestick injuries*; EUCOMED Press Release 10/04

[34] In a case involving a monkeypox infection34, the problems that have arised included not only the unwillingness of the health care workers to provide care to an infection victim and possible negative economic effects on a practice of a "willing provider", but also the problem of health care providers being reluctant to get vaccinated in advance, in order not to be the "first line" of response when any contagious disease emergency arises in future.

Reynolds, G.: *„Why Were Doctors Afraid to Treat Rebecca McLester?"*, The New York Times, April 18, 2004

[35] American Medical Association Code of Medical Ethics declares that a physician *must recognize responsibility, not only to patients, but also to society, to other health professionals, and to self.*

Scribonius Largus each address a general obligation to care for sick patients, including slaves and those who cannot pay, they do not mention infectious risk to physicians[36]. As contagion became a recognized threat, historians have documented that physician performance in the face of this risk was decidedly mixed. Throughout the plagues of Europe many physicians stayed with their patients, but many others fled cities and avoided treating plague victims.[37] The AMA's Code of 1847, the first code of professional ethics, brings a first universal acceptance of the duty to treat patients during epidemies. It states that *„When pestilence prevails, it is duty to face the danger, and continue their labors for the alleviation of suffering, even at the jeopardy of (physicianr's) own lives"*.[38] This unambiguous statement, however, gradually vanishes from the later versions of the Code. In 1912, the sentence *„A physician is free to choose whom he will serve"* was added to the Code. In 1950s, when the epidemies were seen as being on a decline, the rule further eroded. The 1957 Principles of Medical Ethics contain a statement on professional authonomy that referred to a weaker duty to treat: *„A physician may choose whom he will serve. In an emergency, however, he should render service to the best of his ability. Having undertaken the care of a patient, he may not neglect him; and unless he has been discharged he may discontinue his service only after giving adequate notice."* During the following decades, the problem of duty to treat patients in epidemies was considered to be a history, due to eradication of many contagious diseases; most of the relevant discussions were led about the duty to treat HIV positive patients[39].

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[36] Huber, S.J., Wynia, M.K.: *„When Pestilence Prevails…Physician Responsibilities in Epidemics"* The American Journal of Bioethics, 2004; The reason for this is probably that treating physicians did not perceive patients to be «infectious», since the medical science of that times did not recognize the transmission of an infection as a cause of disease.

[37] Ibid.; Even medical heroes fled; both Galen and Sydenham famously fled plagues in their respective eras, following the prescription then commonly given to patients — *cito, longe, tarde*: «leave fast, go far, and return slowly» Very few doctors seem to have expressed any sense of profession-wide duties, but exceptions exist. At the Great Plague of London, in 1666, while many upper-class physicians fled with their rich patients, one humble but now much-quoted apothecary, William Boghurst, wrote that: Every man that undertakes to bee of a profession or takes upon himself an office must take all parts of it, the good and the evil, the pleasure and the pain, the profit and the inconveniences all together and not pick and choose; for Ministers must preach, Captains must fight and Physicians attend upon the sick.

[38] Clark, C.C.: *«In Harm's Way: AMA Physicians and the Duty to Treat»*, Journal of Medicine and Philosophy 2005

[39] Ibid.; a further problem, is that not only has the language been removed from more recent codes, but a study by Alexander and Wynia warns that "both preparedness and the sense of professional obligation to treat patients during epidemics may be declining". The study finds that while 80% of physician respondents reported they would continue to treat patients in the event of an outbreak of an unknown but potentially deadly illness, only 33% reported a willingness to treat if left unvaccinated against a highly contagious and lethal illness like smallpox.

After the 9/11 and during the bioterrorism discussion, the issue of duty to treat patients in epidemies arose once again. The current code, drafted in 2001, reads as follows: *„A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical care."*[40] In interpreting the ethical duty to provide care in emergencies, which includes the duty of a physician to take risks, the revised Oath can be used. Its text says: *„We, the members of the world community of physicians, solemnly commit ourselves to...Apply our knowledge and skills when needed, though doing so may put us at risk."*[41]

It can be concluded that on the ethical level of discussion, the duty of physicians to provide care to infected patients can be found. This may create a perception on the side of public that also a corresponding legal duty exists. The various legal approaches to this problem are compared in the next subsection.

3.3. Legal Obligation to Provide Care

The legal duty of health care professionals to provide care to victims of infectious diseases differs according to the importance the legislation gives to the independence and authonomy of the medical practitioners on one hand, and to the social role of the medical professionals on the other hand. The United States have been traditionally a country with a strong, independent role of the medical profession[42]. In contrast, the Czech Republic is a country with a health care system in which historically the state played an important role. After the emergence of the threat of bioterrorism and of worldwide pandemics such as the avian flu, the regulation of physician duties in emergencies shows signs of convergence, towards the re-establishment of the health care professionalsґ responsibility towards the society in situations of grave dangers.

3.3.1. THE CZECH REPUBLIC

Historically, the health care system of the Czech Republic, or former Czechoslovakia, has been strictly directed by the public regulations. The first social insurance system was established in 1924. In 1948, shortly after the Second World War, substantial political changes took place in the country. The political system became a "people's democracy" and the country was governed by communist ideological principles, linked both politically and economically to the former Soviet Union. As a result, the proportion of nationalized property reached nearly 100%. This influenced many institutions,

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[40] AMA Principles of Medical Ethics (2001), Principle IV., http://www.cirp.org/library/statements/ama/,_accessed 11/25/2005

[41] *Declaration of Professional Responsibility: Medicine's Social Contract with Humanity*, Declaration section 4, http://www.aaaai.org/members/resources/medical_ethics/declaration_responsibility.stm, accessed 11/25/2005

[42] For closer reference, see Starr, P.: *„Social Transformation of the American Medicine"*, Basic Books, New York 1982

including the health care system. Health and social insurance were unified into a compulsory system of insurance for all citizens. Four years later, in January 1952, the centralist system of unified state health care was introduced. The state took over all health care coverage and financed it through taxes. All health care was provided free-of-charge. At the same time, all health care providers were nationalized and subsequently incorporated into regional and district institutes of national health. Since then, all health care facilities were state organisations and all physicians were state employees.[43] Forty years of this experience created an almost universal perception of health care as a public good and a feeling of an universal entitlement to get the health care from a public institution without taking care about the costs. After the 1989 revolution, the Bismarckian system of public health insurance was re-established and a large part of the health services delivery was privatized, but the public sector still plays an important role in health care financing[44].

Despite the system changes, the laws regulating the health care provider duties and public health administration remained largely unchanged. The reason for that is not only the lack of political power on the side of the young physician associations, but more probably the fact that the regulations are generally well known and socially accepted, due to the good results of the public health protection system[45]. Therefore, most of the 1960s health care legislation is still in force[46].

There is a strict duty on the side of health care providers to render the necessary medical help in the case of epidemies. According to the §§ 15 and 16 of the Health Care Codex (Hygiene and epidemiology activities): *The*

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[43] 2005 *Health Systems in Transition (HiT) Czech Republic report* by the WHO European Observatory on Health Care Systems; *Czech Health Care System — Delivery and Financing, Czech Association for Health Services Research*, OECD Study 1999.

[44] The ratio of public to private health care spending in the Czech Republic is 90:10, a highest ratio amongst the European Union countries.

[45] The low respect for patient authonomy and privacy rights allowed the „old" health care system to be quite effective in communicable diseases prevention. Only limited concerns about patient choice and privacy, and universal access to health care, made it possible to establish a directive system of organized preventive examinations, compulsory vaccinations and disease monitoring. The outcome indicators of the pre-1989 system started to get worse after 1970s because of its inability to innovate and react to the growing problem of civilisation diseases, but in the post-war period the results were well comparable to rich Western health care systems, and the system still ranks well in epidemics prevention and neonatal mortality.

[46] Especially the current health care codex, Act Nr. 20/1966 Coll., but the same is true for general legislation such as the 1964 Criminal Code. It is perhaps good to note that during the Cold War, the Czechoslovak Republic was in the most probable war-zone, bordering with Western Germany and Austria, and since late 1960s hosted large Warsaw Pact forces. The country had therefore an extensive program of civilian protection against any kind of nuclear, chemical or biological attacks, in which the health care sector played an important role, so the social obligations of the health care workers have been most probably legislated in accordance with regard to this necessity.

health care facilities...perform also special protective measures against contagious diseases. (these) tasks of health care facilities are fulfilled by their health care workers as an inseparable part of their daily work activity, in a scope corresponding to their work description. In the Czech health care system, almost all physicians working in a hospital settings are hospital employees. Because most of the epidemiologic tasks would be borne by hospitals, the hospital doctors are those who would bear the greatest part of those tasks, as a part of their normal work.

The duties of health care workers are further described in § 55 of the Health Care Code as follows: *„Every health care worker has a duty to perform the health care occupation conscientiously, faithfully, with a deeply humane relation to the citizens and with an awareness of responsibility to the society. Every health care worker has a duty: To assume and duly provide also extraordinary health tasks placed on him/her temporarily in an important public interest...(and)...to immediately render first aid to anyone, if without this help the life or health of such person would be seriously endangered and a timely help is not available on a standard basis..."*

These duties are protected by sanction mechanism. Firstly, all physicians are members of the Czech Medical Association, on a compulsory basis. Losing the Czech Medical Association membership effectively prevents the doctor from practicing medicine[47]. The Association has its disciplinary committee whose powers, as described by law, include the ability to expel members that violate its Code of Ethics or laws of the state. A physician who disregards the aforementioned duties would almost certainly have to face the disciplinary proceedings with a probable termination of membership and resulting loss of the license to practice medicine.

Secondly, the duty to provide necessary aid is enforced by criminal law. According to § 207 of the Criminal Code: *„1) Anyone who fails to provide necessary aid to a person who is in the danger of death or shows signs of a grave health disorder, although he/she could do that without danger for him/herself or other person, shall be punished by imprisonment of up to one year. 2) Anyone who fails to provide necessary aid to a person who is in the danger of death or shows signs of a grave health disorder, although he/she is obliged to render such aid due to the nature of his/her occupation, shall be punished by imprisonment of up to two years or prohibition of activity"*. The first paragraph of the § 207 contains a general duty to render necessary aid to other people whose life or health is endangered. This duty is applicable to any person. The exception to this duty are the situations in which the person providing help would get into a real danger. The second paragraph is a special rule applicable only to those who, due to the nature of their profession and role in the society, have better knowledge, skills or possibilities to provide the necessary aid. These professionals may be for instance firefighters, policemen or health care workers. The important difference in the duty to provide care in the regime of the second paragraph is that the exception of own risk is absent. Therefore, the health care workers cannot refuse to provide medical aid only because the patient might infect them with a dangerous disease.

[47] Act 220/1991 Coll.

Neither of the two sanction mechanisms, disciplinary or criminal, works automatically. In the disciplinary procedure, the Czech Medical Chamber has a discretion whether to punish the doctor by expulsion, by a monetary fine or not to punish the doctor at all. In the criminal law, the act of the accused must fulfill not only the formal aspects of a crime, which are described in §207, but also the material aspects, which are described in the general part of the Criminal Code. One of these material signs of a crime is a so-called „societal dangerousness"; if the act of the accused is not in fact dangerous to the society, then there can be no conviction. Therefore, if the physician for instance fails to provide aid to a dying person, but the help could not save the person or alleviate his suffering and at the same time the attempt to help would lead almost certainly to infecting and killing the physician, neither disciplinary nor criminal sanction would be applied.

3.3.2. THE UNITED STATES AND MSEHPA

Historically, the law of United States respected the physician authonomy in choosing their patients. Under common law, there was no obligation of a physician to engage in treatment of a sick person outside of an already established physician-patient relationship. There are exceptions to this rule, such as the doctrine of implied contract or the statutory duty to provide emergency care under the Emergency Medical Treatment and Active Labor Act (EMTALA)[48]. Those exceptions however would not cover the typical situations arising in epidemies, and are not typically applicable to the duty of physician to report to work.

The Model State Emergency Health Powers Act in its Article IV, section 608 (Licensing and appointment of HC Personnel) states that the public health authority *may exercise, for such period as the state of Public health emergency exists, the following powers...To require in-state health care providers to assist in the performance of vaccination, treatment, examination or testing of any individual as a condition of licensure, authorisation, or the ability to continue to function as a health care provider in this State*

The former version of the MSEHPA included a much stricter duty. Under its Section 502 (Mandatory medical examinations), it was stated that "*the public health authority may exercise, for such period as the state of public health emergency exists, the following emergency powers over persons:...(b) (Health care provider assistance).. To require any physician or other health care provider to perform a medical examination and/or testing. Any person refusing to perform a medical examination or test as authorized herein shall be liable for a misdemeanor*[49].

The first draft of the Act met a critique from civil liberties and physician associations[50]. Under the amended version of MSEHPA, physicians and other

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[48] For more reference on the duty to treat under U.S. law, see White, C.C.: *„Health Care Professionals and Treatment of HIV-Positive Patients: Is There an Affirmative Duty to Treat Under Common Law, the Rehabilitation Act, or the Americans with Disabilities Act?"* The Journal of Legal Medicine, 1999

[49] The Model State Emergency Health Powers Act: as of October 23, 2001, Centers for Disease Control and Prevention, 2001.

[50] Annas, G.J.: *«Bioterrorism, Public Health, and Civil Liberties»*, The New England Journal of Medicine 2001

health care providers can still be required to assist public health officials, but the punishment for not cooperating with the public health authorities is only a possible loss of license, instead of a criminal penalty for noncompliance.

3.4. Compensation for Risks

When the health care workers provide medical aid to the epidemy victims and accept all the risks connected with it, they fulfill an important societal duty. The society should, on its part, recognize the burdens the health care workers bear when they do this work, provide them with all necessary aid and to a maximum extent compensate them for any risks. The compensation should take into consideration all possible dangers, including the risk of being infected, loss of earnings due to a quarantine after being in contact with an infected persons, and support for the family in case of infection-related death of the health care worker.

It might be useful to draw an analogy with compensation of risks in case of military personnel who fight in an armed conflict. The situations are similar: both soldiers and health care workers fulfill a duty for the protection of society against a grave threat (actually, in case of an emergency caused by an act of bioterrorism, the situation may well have all the signs of fighting in a war on own territory). In both cases, those persons are obliged to accept a risk of injury or death. The compensation for possible consequences should therefore not be different. The emergency laws often mention the duty of the health care workers towards the society, but sometimes fail in enacting the corresponding duty of the society towards the health care workers[51].

Special efforts should be made to ensure that health care professionals receive all reasonable preventive and treatment measures in the event of an outbreak of an epidemy, such as vaccines, prophylactic therapies, and safety training. Such preferential treatment makes practical sense, because only healthy practitioners will be of value in responding to any ongoing threat. Ethically, when health care professionals tend to patients in epidemics, healthy people place themselves (and often their families) at risk to benefit the common good. The state must recognize that this burden, in some manner, should be shared by the community as a whole[52].

4. Conclusion

In the first decade of the new millenium, the legal systems seem to be converging in acceptance of the duty of health care workers to provide care in case of public health emergencies, even if it is connected with risks.

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[51] In the Czech Republic, the health care personnel working in areas in which they might come in contact with infected patients receive a risk bonus in addition to their salary. This risk bonus is however unreasonably low, currently less than 2% of the standard salary51. In case of an emergency, no other surplus payments are considered. Furthermore, the risk bonus applies only to employed health care workers.; Kubek, M.: *„Hepatitida za Ctyri Stovky“*, Tempus Medicorum 2001

[52] Wynia, M.K., Gostin, L.O., *«Ethical Challenges in Preparing for Bioterrorism: Barriers Within the Health Care System»*, Government, Politics and Law 2004

Effective handling of an epidemy and protection of lives under a public health emergency is impossible without help of health care workers. In a public health emergency, the individual liberties have to be often limited for the sake of effectivity. A precise legislation is necessary to delimit the possible infringement of individual liberties that would enable an effective management of public health emergencies and at the same time include enough safeguards against political abuse of the emergency powers.

Health care professionals have a duty to care based on several ethical considerations stemming from the Code of Medical Ethics. When the physicians enter their profession, they take an oath that they will be competent, and will use their skills in caring for the sick[53]. These ethical documents and declarations creates a perception among members of public that they wonŕt be deserted by their medical men in a case of an emergency Law should follow the Oath and medical ethics, and transform this ethical obligation into a legal duty.

In my opinion, being a physician or other health care worker carries with itself an inseparable bundle of rights and duties. Risk is part of the profession of medicine, as it is part of the work of the police, firefighters or soldiers. No one has any moral obligation to enter any of those social roles. If, however, they chose to enter public safety roles, then society has the legitimate moral expectation that they will accept the risk attached to those roles. Both the morale and efficiency of police and firefighters and soldiers (not to mention the confidence of the public) would be substantially undermined if individuals in these roles refused to perform their duties in the face of the normal range of risks associated with their roles. The same is certainly true in medicine[54]. There is also a justice argument to be made: as more individual physicians refuse to provide care for infected patients, those physicians remaining to provide care face proportionally greater risks[55]. Therefore, individual health care workers should not be allowed to accept only the benefits of their work including a high social status, but at the same time reject an important part of their duties towards the society.

Finally, in public health emergencies, the health care workers who implement the emergency measures perform the work which is the ultimate responsibility of the government. By offering fair and full compensation of all risks connected with this role, the government can further spread the burden of pursuing the public interest from the health care workers onto the whole society.

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[53] *„Ethics and SARS: Learning Lessons From the Toronto Experience“*, a report by a working group of the University of Toronto Joint Centre for Bioethics, Toronto, Canada, Revised 13th August 2003

[54] Fleck, L.M.: *„Clinicians' Fears, High-Risk Patients & the Duty to Treat; Point — Are There Moral Obligations to Treat SARS Patients?“* Medical Humanities Report 2003

[55] Ibid; maybe a historical analogy exists here. In the end of the 14th Century, a devastating plague swept through the Czech Kingdom. Many of the priests who took their duties seriously and visited the dying got infected and died, whereas the bad priests survived. Two decades later, the Church faced a great crisis, which led to reformation wars. Perhaps one of the reasons of the crisis was that only the immoral, risk-averse clergy survived the plague?

Ондрей Достал

Надання медичної допомоги медичними працівниками під час епідемії: значення, права та обов'язки (порівняльний аналіз)

Метою дослідження є висвітлення та порівняння міжнародних стандартів, законодавства Чеської Республіки та інших держав з точки зору правового регулювання прав та обов'язків медичних працівників під час епідемії. Епідемія — загальносоціальна проблема, під час епідемій інтереси захисту публічного здоров'я можуть переважати над інтересами захисту індивідуальних прав. Попередження та боротьба з епідемією є публічним обов'язком, у виконанні якого важливу роль відіграє професійна діяльність медичних працівників. Основне завдання медичних працівників під час епідемії полягає у максимально можливому збалансуванні публічних інтересів та інтересів окремої людини. Наголошено на важливості неухильного дотримання медичними працівниками вимог Міжнародного етичного кодексу, окремі з яких трансформувались в обов'язки, закріплені національним законодавством.

Проаналізовано положення Конвенції з прав людини та основоположних свобод (1950), Конституційного Закону Чеської Республіки з питань епідемії та Медичного кодексу, а також модель організації професійної діяльності медичних працівників за законодавством Сполучених Штатів Америки з точки зору з'ясування необхідності, ефективності та умов виконання медичними працівниками професійних обов'язків, які передбачені зазначеними актами, в умовах надзвичайних ситуацій.

У статті висвітлено проблемні питання, які стосуються реалізації окремих прав і виконання обов'язків медичними працівниками під час надання медичної допомоги в невідкладних та екстремальних ситуаціях, а також запропоновано можливі шляхи законодавчого вирішення зазначених проблем. У разі виникнення надзвичайних ситуацій, пов'язаних із загрозою здоров'ю населення, медичні працівники, які вживають відповідних заходів, тим самим виконують роботу, що одночасно є обов'язком уряду. Запропоновано впровадження механізму повної компенсації усіх ризиків, пов'язаних з виконанням професійних обов'язків медичними працівниками в зазначених умовах.

Ондрей Достал

Предоставление медицинской помощи медицинскими работниками во время эпидемии: значение, права и обязанности (сравнительный анализ)

Целью исследования являются освещение и сравнение международных стандартов, законодательства Чешской Республики и других государств с точки зрения правового регулирования прав и обязанностей медицинских работников во время эпидемии. Эпидемия — общесоциальная проблема, во время которой интересы защиты публичного здоровья могут преобладать над защитой индивидуальных прав. Предупреждение и борьба с эпидемией выступают публичной обязанностью, важную роль в выполнении которой играет профессиональная деятельность медицин-

ских работников. Основная задача медицинских работников во время эпидемии состоит в максимально возможном сбалансировании публичных интересов и интересов отдельно взятого человека. Сделан акцент на неуклонном соблюдении медицинскими работниками требований Международного этического кодекса, отдельные из которых трансформировались в обязанности, предусмотренные национальным законодательством.

Проанализированы положения Конвенции по правам человека и основоположных свобод (1950), Конституционного Закона Чешской Республики по вопросам эпидемии и Медицинского кодекса, а также модель организации профессиональной деятельности медицинских работников по законодательству Соединенных Штатов Америки, на предмет выяснения необходимости, уровня эффективности и условий выполнения медицинскими работниками профессиональных обязанностей, предусмотренных указанными актами, в условиях чрезвычайных ситуаций.

В работе рассмотрены проблемные вопросы, касающиеся реализации отдельных прав и выполнения обязанностей медицинскими работниками во время предоставления медпомощи в период чрезвычайных ситуаций, а также предложены возможные пути законодательного решения указанных проблем. В случае возникновения чрезвычайных ситуаций, связанных с угрозой здоровью населения, медицинские работники, принимающие соответствующие меры, тем самым выполняют работу, которая одновременно является обязанностью правительства. Предложено внедрение механизма полной компенсации всех рисков, связанных с выполнением профессиональных обязанностей медицинскими работниками в указанных условиях.