What Should I Do?

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The aim of the study was to examine the conflicting duties of a practicing surgeon who is at high risk for morbidity and mortality from Covid-19 infection. Should he opt out of the care of these patients or does his duty to care override other considerations? Older adults and those with serious medical conditions are at much greater risk for severe disease and death from Covid-19 infection. As a practicing frontline surgeon in a high risk group, the hospital offered the author, and other health care providers at high risk, the option to opt out of the care Covid-19 suspected or infected patients before an anticipated surge. What should the surgeon and other health care providers do? This is a question many are asking and having to answer. In this article, the author describes how difficult the situation of having any choice at all was and then how difficult it was to arrive at a decision. The duty to care and its limits, as well as obligations to society, family, co-workers, and to self, are examined. The author considers how he and others can contribute in other ways to patients and providers. The author arrives at a morally permissible and a rational decision to opt out. Health care workers at high risk can contribute in other ways to patients and providers. It still may not feel right.

Keywords: COVID-19, duty to care, high risk health care workers, opt out

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My ''duty to care'' seemed crystal clear to me as the Covid-19 pandemic unfolded. As a practicing surgeon at the frontline of caring for high risk patients, I assumed that is where I would stay. In 2 to 4 weeks, my hospital will see its Covid-19 surge. Unexpectedly, I received an email offering me the option of ''opting out'' of the care of infected patients. I am 68 years' old with reactive airway disease that places me in a high-risk group. My wife immediately said I should opt out, not for her safety, but for mine—but the way forward was not clear to me. I almost wished the option wasn ot given. The conflict comes from not only making the right choice, but from having a choice at all—and from evaluating those choices through multiple lenses, balancing duty to care, duty to society, duty to family, duty to co-workers, and duty to self. What should I do?

Early data on Covid-19 infections from China, Italy, and the United States, demonstrate the risk of severe disease and death are greater in older adults and those with chronic lung and heart disease and other serious medical conditions.[1,2] In the United States, 31% of Covid-19 cases, 45% of hospitalizations, 53% of intensive care unit (ICU) admissions, and 80% of deaths occurred in adults 65 years and older, even though they make up only 16% of the general population.[1] Case-fatality rates increase with age: 0% for 0 to 19 years; 0.1% to 0.2% for 20 to 44 years; 0.5% to 0.8% for 45 to 64 years; 1.4% to 2.6% for 55 to 64 years; 2.7% to 4.9% for 65 to 74 years; 4.3% to 10.5% for 75 to 84 years; 6.3% to 29% for $\geq$85 years.[1]

Case fatality rates for patients under 50 years are $<$0.5%, but are likely to actually be $<$0.05% because of the large number of untested, mildly symptomatic, and asymptomatic young patients missing from the denominator.[1,2] Thus, the risk of death for a 68–year-old like me could be as high as 100 times that of a 50-year-old (4.9% vs 0.05%) and could be even greater compared to younger individuals, a highly unfavorable risk profile.

Health care workers enter their professions accepting they have a ''duty to care'' for all patients equally including patients with communicable diseases. The ''World Medical Association Declaration of Geneva'' states that as a member of the medical profession: ''I will not permit considerations of age, disease, or disability, creed, ethnic origin, sex, nationality, political affiliation, race, sexual orientation, social standing, or any other factor to intervene between my duty and my patient.'' The ''AMA Code of Ethics' Opinion on Physician Duty to Treat'' states: ''Because of their commitment to care for the sick and injured, individual physicians have an obligation to provide urgent medical care during disasters. This ethical obligation holds even in the face of greater than usual risks to their own safety, health, or life.''

And yet, is the ''duty to care'' absolute and independent of the degree of risk? According to Kant's theory of duty, a moral obligation must be universal, such that it can be applied in all circumstances by all individual moral agents—the ''categorical imperative''—and the moral worth of an act depends on whether the act is done in accordance with and for the sake of the duty, not the expected outcome the act brings. An examination of 3 formulations of the categorical imperative finds that a change of duty based on high risk would violate each formulation.[3] Kant appears to leave no room for changes in my obligations of duty to care based on increased risk.

Consider an alternative view. Rawlsian egalitarian principles of justice that apply to the distribution of social benefits, can also be applied to how social burdens are distributed.[4] According to this application of justice, putting burdens on those ''least able to bear them'' (those already relatively worse off, or more vulnerable than others) is detrimental to the ideal of equality of opportunity. Thus, the general principle of ''placing burdens on those best able to bear them'' would support the exclusion of older providers, arguing that younger providers are better able to bear the risks of caring for Covid-19 patients. Even so, I struggle with the idea of shifting the burden to my younger, still at risk, colleagues. As a young surgeon in the early days of the HIV epidemic, I cared for HIV-positive patients when colleagues declined. It troubles me to now consider being on the other side.

There are some that believe healthcare workers who become ill should receive preference if rationing of beds and ventilators is required, not because they are more deserving, but because of their instrumental value caring for patients.[5] If preference is given to health care workers, then some high-risk providers might be more willing to take on the risk of caring for Covid-19 patients. I personally do not believe health care workers should receive priority, and did not factor this into my decision.

My wife and children have implored me to opt out because of their concern for me, not themselves. I agonize, as I am sure all health care providers do, over balancing obligations to patients and family—wanting to protect ourselves and our family members. Society accepts we have special obligations to family that may take precedence over obligations to others. If a person witnesses 2 children

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drowning, and one is their child, most would agree that it is morally acceptable to save their child first. We also accept that deceased donor organs can be directed to a family member, bypassing established allocation policies. When a family member or friend has special needs, our sense of responsibility may be even greater. When health care providers, particularly those at highest risk, choose to prioritize their health and safety based on family and other personal obligations, these choices should be respected as ethically justifiable.

If older and at-risk providers become ill with Covid-19, they are much more likely to require hospitalization, ICU care, and ventilator support, diverting vital resources that may be needed for other patients. They will be unavailable for patient care for an extended period of time. From a resource utilization perspective, logic would recommend high-risk providers not be placed in perilous situations.

If I, and others like me, opt out, what else can we do to make a difference in these difficult times? Other non-Covid-19 patients require care, and older and more vulnerable providers can take on this load to free up other providers. As experienced and senior providers, we can make virtual rounds from a distance, review laboratory results and imaging studies, help integrate consultants' recommendations into a coordinated care plan, and maintain the electronic medical record. We can serve as a support system for frontline providers and assist in scarce resource allocation, such as decision-making around ventilator and ICU bed allocation, bringing value to patients and providers.

What did I decide? In one of the most difficult decisions I have ever made, I opted out. My family, friends, and colleagues, young, old, and in between, have been supportive. I believe I made a morally permissible and a rational decision, but it still does not feel right. What happens when the patient and hospital needs reach an ''all hands on deck'' status? What will I do then? What should I do?

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