Ethical Issues Encountered During the SARS Crisis

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A summary of the ethical issues of the SARS crisis as presented by bioethicist Dr. Peter Singer and colleagues in the article "Ethics and SARS: lessons from Toronto".

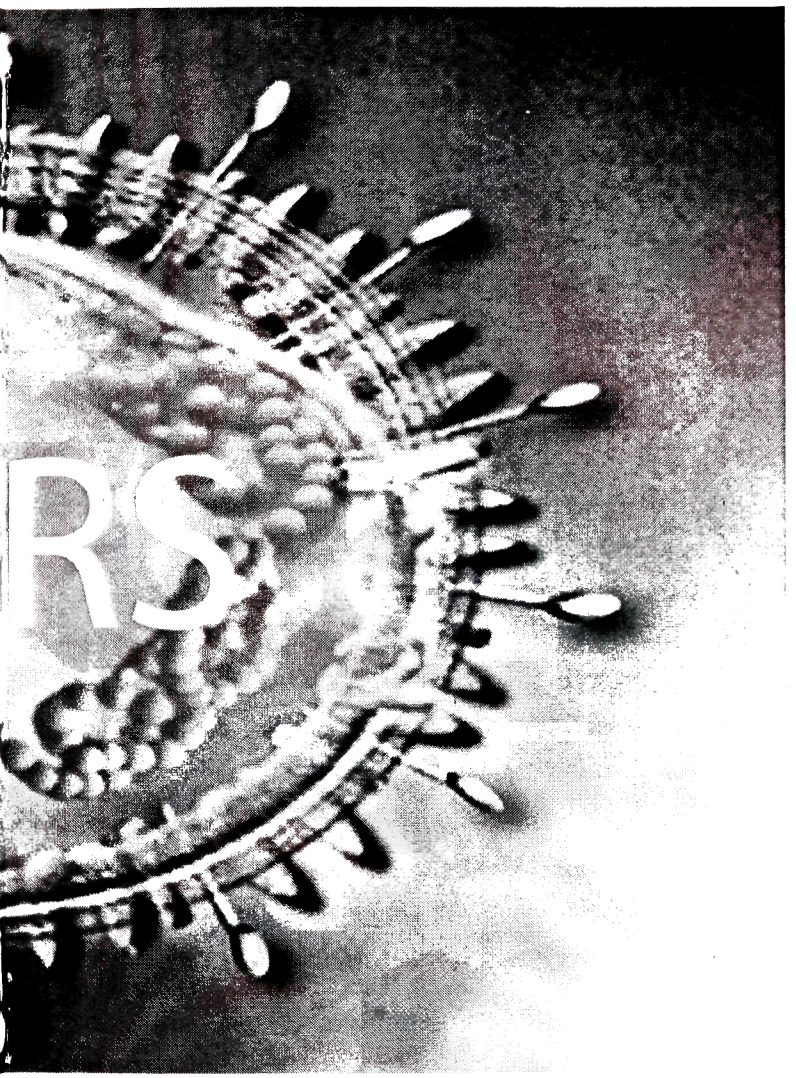
The sudden outbreak of severe acute respiratory syndrome (SARS) in Canada was accompanied with many ethical dilemmas. Choices had to be made regarding enforcement of quarantine, public identification of diseased individuals, the extent to which health care professionals were expected to provide care, resource allocation to waiting patients, and suppression of global spread. Each course of action was associated with a specific value judgement, a prioritization of one ethical value over another. In a recent article in the *British Medical Journal*, Dr. Peter Singer and colleagues explored the ethical values that were compared during this crisis. This review summarizes the insight garnered from that paper, and examines five of the major ethical issues that the group of health care professionals and ethicists identified.

1. Ethics of Quarantine

During the propagation of a deadly, contagious disease like SARS, it is in the public's best interest to quarantine those who may have been exposed to the infectious agent. Through such an action, many more lives may be protected from harm. However, the temptation to immediately impose mandatory quarantine is opposed by the need to consider the rights of all the individuals who will be affected. Those quarantined may face undue threats to their individual liberty, economic status, and health if appropriate action is not taken to consider their needs. To balance the interests of the individual and the public, the value of proportionality must be adopted. The idea promotes the use of minimal amount of intrusion to the individual while making proportionate sacrifices for the greater good. More severe threats to public health may necessitate greater individual sacrifices. By employing the minimum restrictions that succeed in protecting public health, a fair compromise between individual liberty and public interest can be reached. Furthermore, to offset the sacrifices of the quarantined, compensation should be allocated according to the principle of reciprocity. Special provisions should be made to ensure that affected individuals receive the health care they require and reparation for their economic losses.

2. Privacy of Personal Information and Public Need to Know

Under normal circumstances, individuals who are diagnosed with a particular disease have the right to privacy about their condition, which offers protection of their personal lives from the discriminating effects of public scrutiny. Nevertheless, when disclosure of their infection status would significantly help prevent public transmission and serious harm to others, this



right can be superseded for the greater good. When this course of action is adopted, the benefit to the public must be balanced against the cost to the individual. Determination of when risks to public health take precedence over personal privacy should depend on the severity of the disease and whether or not a "well-defined public health goal can be achieved by making personal information public". According to the value of proportionality, private information should only be disclosed as a last resort to protect public health, if no other means are available.

3. Duty of Care

During the SARS crisis, health care workers had to make important decisions about whether to protect themselves against the disease or to fulfill their duty to care for others. On one hand, health care workers were professionally responsible for their patients and the public relied on their expertise to maintain the health of the community. On the other hand, there was a limit to the extent of expected heroic commitment if the duties presented serious harm to themselves and to their families. Furthermore, health care workers were professionally responsible for maintaining their own health in order to provide care for others.

Currently, there is disagreement regarding how much exposure health care providers are professionally obligated to accept. Further research, along with input from the public, health care providers and regulatory bodies, is required to reach a consensus decision. For the workers who place themselves at risk, institutions should fulfil the duty of reciprocity by providing protection, interventions to help them cope with the extreme stress, acknowledgement of their selfless acts, and support plans in emergency situations.

4. Collateral Damage

In addition to the direct effects of SARS, thousands of patients were adversely affected by the restrictions placed on hospital admissions. Individuals with varying afflictions, sometimes as serious as heart disease and cancer, were confronted with serious barriers and delays to care. In addition, those who were admitted faced the loss of contact and emotional support from family and friends as a result of the hospitals' strict isolation policies.

This collateral damage is an inevitable consequence of efforts to contain the spread of the disease; however, determining the point at which the benefits of public health protection initiatives outweigh the costs to waiting patients that require care presents a challenging ethical dilemma. An analysis of the "risks, benefits, and opportunity" costs must be performed to determine which "medical services to maintain and which to place on hold".

5. Global Issues

Modern transportation has allowed for the rapid transmission of infectious diseases across the globe. SARS rode halfway around the world on an airplane to reach Canada. This example illustrates the necessity for solidarity amongst the nations to protect themselves and each other against such threats to global health. In light of the interconnected nature of today's world, it is neither ethical nor acceptable to conceal health information that can protect others. Had China stepped forward earlier with information about the disease and its origins, the spread of SARS may have been reduced. To establish effective global health protection, Dr. Peter Singer and colleagues encourage transparency, honesty, and good communication within the worldwide community.

Conclusion

Sudden outbreaks of diseases like SARS place enormous stress on the health care system and force health care providers to make difficult ethical decisions that require the prioritization of various values. Careful consideration of the benefits and costs to patients, the public, health care providers, and other nations must be taken into account. Decisions should simultaneously respect individual liberty, personal privacy, proportionality, and reciprocity while upholding health care workers' duty to caring and protecting the public from harm. M

For the full version of the article, read:
Ethics and SARS: lessons from Toronto (Singer et al., 2003)

Preparing for the Next SARS Epidemic

Exploring Treatment Development and Vaccination Options

Brent Mollon

On October 16, 2002 the first case of Severe Acute Respiratory Syndrome (SARS) was reported in Guangdong Province of the People's Republic of China (Hawkey, Bhagani & Gillespie, 2003; Stavrinides & Guttman, 2003). The outbreak of SARS then spread from Guangdong to more than 30 countries around the world, using air travel as a means of dissemination (Stavrinides & Guttman, 2003). As illustrated by the World Health Organization (WHO) in a report entitled "Severe acute respiratory syndrome (SARS): status of the outbreak and lessons for the immediate future", there are several aspects of SARS that make it particularly dangerous. The first and perhaps most imperative feature is that there is currently no vaccine or treatment for this new virus. The lack of medicinal tools forced doctors to resort to quarantine in attempt to halt the spread of SARS. Even diagnosis of the disease was difficult, as the initial symptoms of SARS are common to other viruses, like influenza, and may vary amongst patients. Detection of the virus is further complicated by the testing limitations. These tests may result in improper diagnosis if inaccurately conducted or incorrectly analyzed. With these complications aside, the initial stages of SARS seemed to affect the health care system more than the general public (Emanuel, 2003). Over half of the initial 60 reported cases of SARS were health care workers. Once the epidemic spread to Canada, SARS continued to subject the lives of our health care professionals at risk. From February 23, 2002 to May 14, 2003, 65% of suspected Canadian SARS cases were health care workers (Emanuel, 2003).

In the struggle to contain the growing epidemic, the WHO issued a global alert on March 12, 2003 (Groneberg, Zhang, Welte, Zabel & Chung, 2003). This warning, along with the quarantine of infected individuals, face masks, and preventative measures, were implemented in hospitals and on the general public, and allowed SARS to be contained before it became uncontrollable. Although the 8098 cases of SARS and 774 resultant deaths (reported by the WHO as of July 11, 2003) may appear minute compared to the millions of deaths resulting from other viral