The Duty to Care

When Health Care Workers Face Personal Risk

Marie T. Hilliard, R.N.

A pandemic due to the avian flu virus (H5N1) is possible, and if it occurs, the event will not be unfamiliar to health care workers. History provides us with numerous examples. In the twentieth century alone, there were three pandemics, the largest being the 1918 "Spanish" influenza pandemic, in which forty to fifty million people died worldwide within one year.[1] Five hundred thousand persons died in the United States alone.[2] Such crises have generated heroic responses by health care workers. The question that arises today is whether such heroism will prevail in the face of varying perceptions concerning the duty of health care workers to care?

The World Health Organization (WHO) has stated that an influenza pandemic is possibly imminent.[3] In 1997, the first documented H5N1 infections in humans

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Marie T. Hilliard, J.C.L., Ph.D., R.N., is director of bioethics and public policy at The National Catholic Bioethics Center in Philadelphia.

[1] Colin Lowry, "Last Chance to Stop Avian Flu Pandemic," *21st Century Science and Technology* 18.3 (Fall 2005): 32.

[2] Channing Bete Company, "How You Can Be Prepared for a Flu Pandemic: An Individual and Family Handbook" (Deerfield, MA: Channing Bete, 2006), 5, distributed by the State of Connecticut Comptroller's Office and Anthem Blue Cross and Blue Shield of Connecticut.

[3] Pan American Health Organization and World Health Organization, Subcommittee on Planning and Programming of the Executive Committee, Fortieth Session, "Influenza Epidemic: Progress Report," February 16, 2006 (SPP40/5), 6, http://www.ops-oms.org/english/gov/ce/spp/spp40-05-e.pdf.

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occurred; mortality rates in humans with the disease are over 50 percent.[4] As of August 2007, 199 persons in nine countries have died from H5N1.[5] It is estimated that in the United States alone such a pandemic could kill almost two million persons.[6] National preparedness plans are underway, involving health care workers and agencies.

Part of this preparedness includes surveying health care workers to determine their willingness to provide care during a pandemic. One study suggests that nearly half of local health department workers are likely not to report to duty; however, clinical staffers are more likely to report than technical and support staff.[7] Another study was conducted in conjunction with an emergency preparedness training program for school health nurses. Ninety percent of these nurses reported at least one barrier to reporting for duty in the event of such an emergency. Barriers frequently reported were family care responsibilities, transportation, and personal health issues.[8] A study of the nature of the catastrophic event, and of the self-reported ability and willingness of health care workers to report to duty, indicates that health care workers were least willing to report to duty during a sudden acute respiratory distress syndrome (SARS) outbreak (48 percent). Concerns affecting willingness to report to duty include fear and concern for family and self, and personal health problems.[9]

In fact, health care workers, including those who had recovered from SARS, have fears of infecting others, especially family members, equal to, if not greater than, fears for their own health.[10] Research indicates that providing treatment on site for family members increases the commitment to work of health care providers.[11] Furthermore, health care workers were perceived as a potential source of infection in the community.[12] Because of the similarities of the health impacts of an avian flu pandemic and the SARS coronavirus outbreak of 2003, such findings do not bode well for addressing public health needs in an avian flu pandemic.

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[4] Lowry, "Last Chance," 27, 29.

[5] World Health Organization, "Cumulative Number of Confirmed Human Cases of Avian Influenza A/(H5N1) Reported to WHO," August 31, 2007, http://www.who.int/csr/disease/avian_influenza/country/cases_table_2007_08_31/en/index.html.

[6] Channing Bete, "How You Can Be Prepared," 5.

[7] R. D. Balicer et al., "Local Public Health Workers' Perceptions toward Responding to an Influenza Pandemic," *BMC Public Health* 6 (April 18, 2006): 99, http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=1459127.

[8] K. A. Qureshi et al., "Emergency Preparedness Training for Public Health Nurses: A Pilot Study," *Journal of Urban Health* 79.3 (September 2002): 413–416.

[9] K. A. Qureshi et al., "Health Care Workers' Ability and Willingness to Report to Duty during Catastrophic Disasters," *Journal of Urban Health* 82.3 (September 2005): 378–388.

[10] S. M. Ho et al., "Fear of Severe Acute Respiratory Syndrome (SARS) among Health Care Workers," *Journal of Consulting and Clinical Psychology* 73.2 (April 2005): 344–349.

[11] J. I. Syrett et al., "Will Emergency Health Care Providers Respond to Mass Casualty Incidents?" *Prehospital Emergency Care* 11.1 (January–March 2007): 49–54.

[12] Y. H. Dessmon, "SARS Plague: Duty of Care or Medical Heroism," *Annals of the Academy of Medicine, Singapore* 35.5 (May 2006) 374–378.

Legal Perspectives

In examining the imperatives to care, analyses have been provided from legal, ethical, and moral perspectives. Legally, the issue of the duty to care is framed in the context of medical negligence and liability. The three-pronged analysis of liability is constructed in the framework preventing the occurrence of any damage. This analysis dictates that the damage must be a reasonable, foreseeable consequence of the negligence, there must be a proximate relationship of the health care provider to the victim, and the imposed liability must be just and convenient.[13] Duty to care is linked to a voluntary assumption of responsibility, including fiscal responsibility for claims of negligence.

Legally, in the absence of a physician–patient relationship, a physician can refuse to provide care. However, a physician has a duty to care for those with whom he or she has established a physician–patient relationship.[14] Furthermore, health care facilities accepting certain types of public funding may have obligations to treat certain categories of patients under certain conditions. Also, emergency rooms may be required to provide care to those presenting themselves with life-threatening conditions.[15]

Negligence is also addressed from a legal perspective in state practice acts. The National Council of State Boards of Nursing, in its model nursing practice act, does address negligence, but only in terms of reporting negligent behavior of the licensed professional. Moral turpitude is also addressed and is defined, in part, as "conduct that involves one or more of the following: intentional, knowing or reckless conduct that causes injury or places another in fear of imminent harm; conduct done knowingly contrary to justice or honesty; [or] conduct that is contrary to the accepted and customary rule of right and duty that a person owes to fellow human beings and society in general."[16] Of import is the last descriptor, which acknowledges that the nurse has a duty to "fellow human beings and society in general." However, nowhere does the model nursing practice act explicate this text.

"A Guide to Essentials in a Modern Medical Practice Act," by the Federation of State Medical Boards of the United States, also contains a reference to negligence; however, negligence is to be defined by the state medical board. The guide does not contain the word "duty." It does reference moral turpitude, but only as an unlawful act as determined by a court of competent jurisdiction.[17] Therefore, the law provides us with little guidance, from a legal perspective, pursuant to a duty to care.

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[13] Suresh Nair, "Medical Negligence: Duty of Care," abridged, *SMA News* (1992):1, http://www.sma.org.sg/sma_news/3307/duty_of_care.pdf.

[14] Ibid., 2.

[15] "Establishing a Duty of Medical Care," Buchanan & Beckering P.L.C. Web site, accessed September 13, 2007, http://www.michiganpatient.com/michigan_medical_malpractice_duty_of_care.php.

[16] National Council of State Boards of Nursing (NCSBN), "Model Nursing Practice Act" (2002), III.4Z, https://www.ncsbn.org/Model_Nursing_Act_and_Rules_Full.pdf.

[17] Federation of State Medical Boards of the United States, House of Delegates, "A Guide to the Essentials of a Modern Medical Practice Act," 10th ed. (April 2003), http://www.fsmb.org/pdf/2003_grpol_Modern_Medical_Practice_Act.pdf.

Ethical Standards of Care

In the absence of legal directions concerning a duty to care in a pandemic, one can look toward ethical standards of care. There are those who hold that the duty to care is ethically obligatory for anyone who assumes the responsibilities of a chosen health care profession. Furthermore, duty of care can be used as a subtle instrument of intimidation of health care workers.[18] Society does have expectations of health care professionals, to whom they have provided special privileges, be it as simple as access to MD license plates for their cars. Signs of these societal expectations are obvious, as well as subtle. A daily calendar, usually given as a gift to a nurse, lists five reasons for becoming a nurse. Listed as number one of these reasons is "You can expose yourself to rare, exciting, and new diseases."[19] Although stated in jest, it clearly indicates societal expectations.

From an ethical perspective the term "duty of care" (used synonymously with "duty to care") refers to these special obligations; that is, doctors and nurses have a greater obligation of beneficence than most others. Beneficence is a foundational principle of the patient–provider relationship,[20] to further patient welfare and to advance patient well-being.[21] These special obligations exist for three reasons: health care professionals have a proportionally greater ability (than the public) to provide care; professionals, in choosing their professions, have assumed the risks of providing care; and the professions are legitimated by their contracts with society, resulting in the obligation of professionals to be available in times of emergency.[22] Furthermore, doctors give implicit consent to assuming the risks and responsibilities associated with the specialties in which they agree to practice. In a pandemic, the risks to health care workers are real: In the 2003 SARS outbreak, 30 percent of cases were among health care professionals, some of whom died from the infection. In fact, Dr. Carlo Urbani of the World Health Organization succumbed to the virus, which he acquired while carrying out his professional duties.[23] In seeking guidance for responding to such dilemmas, one would hope to find it in the professional codes of ethics.

In examining statements from professional associations, one finds an ethical stance indicating that the duty of care is neither fixed nor absolute, but contextual. Factors to be considered are the risk level of the working environment (e.g., lack of

[18] Daniel K. Sokol, "Virulent Epidemics and Scope of Healthcare Workers' Duty of Care," *Emerging Infectious Diseases* 12.8 (August 2006): 1238, http://www.cdc.gov/ncidod/EID/vol12no08/pdfs/06-0360.pdf.

[19] "Five Reasons to Become a Nurse," *Nurses 2007 Desk Calendar*, January 17, 2007 (Kansas City, MO: Andrews McMeel Publishing, 2006).

[20] P. Entralgo, S. Bloom, R. Purtilo, "Professional-Patient Relationship," in *Encyclopedia of Bioethics*, ed. W. Reich (New York: Simon & Schuster, 1995).

[21] Carly Ruderman et al., "On Pandemics and the Duty to Care: Whose Duty? Who Cares?" *BMC Medical Ethics* 7.5 (April 20, 2006): 3, http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=1459179.

[22] Ibid., 3.

[23] Ibid., 1–3.

protective equipment), the specialty of the health care worker, the likelihood of harm related to the benefits of care, and competing obligations of the health care worker as a member of a family and a community.[24] There are those who believe that health care workers have a right to resign from their positions when they believe their responsibilities to family outweigh those to the community.[25] In retrospect, one could ask whether, on September 11, 2001, New York City firefighters would have been justified in not attempting to ascend 110 flights of stairs in the World Trade Center.

In June 2004, in the aftermath of 9/11, the American Medical Association adopted an ethical policy statement, "Physician Obligation in Disaster Preparedness and Response." This policy states, in part:

> National, regional, and local responses to epidemics, terrorist attacks, and other disasters require extensive involvement of physicians. 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. The physician workforce, however, is not an unlimited resource; therefore, when participating in disaster responses, physicians should balance immediate benefits to individual patients with ability to care for patients in the future.[26]

As admirable as these words seem, they reflect a weakening from earlier policy statements, which, until 1970, included an admonition to alleviate suffering, even to the point of jeopardizing one's own life.[27]

The American Nurses Association has adopted a position statement which provides an ethical framework for nurses to determine if they have a duty to care. The statement recognizes the risks inherent in caring for those with communicable diseases:

> Even with the benefit of the recognition of risk and responsibility with guidelines for prevention, it is the nature of health problems such as acquired immunodeficiency syndrome (AIDS), cytomegalovirus (CMV), hepatitis B or C, human immunodeficiency virus (HIV), severe acute respiratory syndrome (SARS), the threat of bioterrorism agents, including bubonic or pneumonic plague, smallpox, and viral hemorrhagic fever, and other newly diagnosed infectious diseases which may raise questions for the nurse regarding personal risk and responsibility for care of the patient.[28]

In the face of such risks, the nurse is to differentiate between a moral obligation, or duty, and a moral option to care. Four fundamental criteria are presented, to assist in determining whether a moral obligation to care exists for the nurse. If all four of the

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[24] Sokol, "Virulent Epidemics," 1238–1239.

[25] Dessmon, "SARS Plague," 374–378.

[26] American Medical Association, "Physician Obligation in Disaster Preparedness and Response," *AMA Code of Medical Ethics,* policy E-9.067, http://www.ama-assn.org/apps/pf_new/pf_online?f_n=browse&doc=policyfiles/HnE/E-9.067.HTM.

[27] Ruderman, "On Pandemics," 5.

[28] American Nurses Association, "Risk and Responsibility" position statement, June 21, 2006, 3, available from the ANA or online at http://www.needlestick.org/readroom/position/ethics/RiskandResponsibility07.pdf.

following criteria are present, a duty to care exists: the patient is at significant risk of harm, loss, or damage if the nurse does not assist; the nurse's intervention or care is directly relevant to preventing harm; the nurse's care will probably prevent harm, loss, or damage to the patient; and the benefit the patient will gain outweighs any harm the nurse might incur and does not present more than an acceptable risk to the nurse.[29] As with that of the American Medical Association, this position reflects a change in historical thinking on this matter. In 1926, a suggested code of ethics, which was published but never adopted, contained the following phrase: "the most precious possession of this profession is the ideal of service, extending even to the sacrifice of life itself."[30] Thus, there appears to be ambiguity in both professions' understandings of the ethical duty to care in the face of personal risk.

Philosophical Approaches

Ethical frameworks have been developed to assist in resolving such ethical situations or dilemmas. "Ethical situations" are topics of current interest in applied bioethics which illustrate ethical concepts, such as allocation of resources.[31] In such situations, one usually finds two goods, such as justice and beneficence, in conflict. Ethical frameworks apply "ethical theories" to these situations or dilemmas. Ethical theories are the analytical methods or modes of philosophical reasoning (e.g., subjective and objective methods) utilized in ethical decision making in these situations.[32] The problem is that these analytical methods vary greatly, potentially providing even less guidance than the previously mentioned legal frameworks and codes of ethics.

Subjective methods are relativistic in approach. No human act, in and of itself, is considered good or bad. The act is made good or bad relative to some other criterion. Relativist ethics include situationism, consequentialism, and utilitarianism. In situationism, an act is judged in the situation in which it is performed. The intent of the act is the criterion that determines the ethicalness of the act; for example, "I intend that my family remains healthy; therefore, I will not report to work in the event of a pandemic." In consequentialism, the end justifies the means; for example, "By not reporting to duty in a pandemic, I will not get sick." Thus, the ethicalness of the act is determined by the foreseen consequences, although some would hold that it is impossible to foresee all the consequences. In utilitarianism, the ethicalness is determined by the greatest good for the greatest number, as in triage. Utilitarian reasoning could lead a health care worker to conclude that it would be justified not to report to duty

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[29] Ibid.

[30] American Nurses Association, "A Suggested Code," *American Journal of Nursing*, August 1926. See also K. G. Hook and G. B. White, "Code of Ethics for Nurses with Interpretive Statements," ANA continuing education module, 2001, 3, http://nursingworld.org/mods/mod580/code.pdf, for a time line of the development of nursing's code of ethics.

[31] Rita Jean Payton, "A Bioethical Program for Baccalaureate Nursing Students" in *Ethics in Nursing Practice and Education*, ed. American Nurses Association Committee on Ethics (Kansas City, MO: ANA, 1980), 57–59.

[32] Ibid., 57–58.

during a pandemic because, "If I report to duty and get sick, I cannot help numerous others in need." From a utilitarian perspective, the "good" is determined by whatever maximizes pleasure and minimizes pain for the greatest number of persons. In fact, such an approach dictates the way in which many of our laws are promulgated. In such a case, recipients of these acts would hope to be in the majority. However, John Rawls holds that individuals have a duty to act according to the laws that they would propose if they were unaware of their present socioeconomic status; that is, in this case, access to health care providers would not be based on socioeconomic status. This is the foundation of John Rawls's rules by social contract.[33] Thus, his reasoning also is considered to be objective, as in deontological reasoning.

Objective methods dictate that some actions may never be done regardless of the circumstances. Actions are only hypothetically indifferent (e.g., speaking versus giving a verbal order for morphine administration). Included in these methods are principled reasoning, such as deontological reasoning, and law ethics. Kant's deontological reasoning dictates that one is to act only according to universal maxims; that is, one would will that those maxims would become universal laws.[34] Therefore, one always is to report to duty, in all circumstances. Deontological methods embrace duty and obligation, the substance of the question being addressed here. Duty and obligation are the very motives for action, regardless of the consequences. Acts are not performed to achieve happiness, but for duty's sake. This reasoning can lead to a form of legal positivism, that is, as long as the law dictates an action, it is ethical. The problem is that laws can change and may reflect the lowest common denominator. Reliance on the law by some physicians in Nazi Germany led to the Nuremberg Trials.

Ethic of the Good

Having examined legal imperatives and ethical reasoning, we move to a moral perspective, reflected in the "ethic of the good." The ethic of the good embraces the objective method of reasoning by the virtuous person. The concept of the virtuous person was proposed by Socrates, developed by Plato, and advanced by Aristotle. Aristotle held that the soul of the person is fitted by nature for virtue, but that virtue has to be acquired through sound choice. The virtuous person acts reasonably, by acting on behalf of ends rightly perceived as goods in pursuit of happiness. This is consistent with natural moral law. From the perspective of St. Thomas Aquinas, God, the Creator of human nature, is the ultimate source of this happiness.[35] Whether from a theological or an Aristotelian perspective, natural moral law is part of the natural order, and thus is consistent with reasoning. The virtuous person would report to duty in a pandemic because it is virtuous to serve others in need. The "golden rule" fosters the good of society, leading to happiness. This same virtuous person also would act

[33] John Rawls, *A Theory of Justice*, rev. ed. (Oxford: Oxford University Press, 1999).

[34] Immanuel Kant, *The Metaphysics of Morals*, trans. and ed. Mary J. Gregor (Cambridge, U.K.: Cambridge University Press, 1996).

[35] Thomas Aquinas, *Summa theologiae*, trans. Fathers of the English Dominican Province (New York: Benziger, 1947).

reasonably in assuming duties. For example, a nurse with an immunosuppressed family member in his or her household would not take on the responsibilities of a direct care giver to those who have contracted a pandemic flu.

The health care professional is not the only one with a moral duty; society has the duty to protect the health care worker by providing protective equipment, antiviral medications, and available vaccines. Furthermore, the provision of sufficient health care workers, through aids and incentives for preparation, recruitment and retention programs, is a societal responsibility. Thus, beneficence is not the only ethical principle at issue; justice also is, as it pertains to allocation of resources, particularly the allocation of health care providers. In earlier research, this author defined justice, pursuant to the obligations of the health care worker, as the equal distribution of rights and resources to all patients.[36] However, it became apparent through that research that all patients do not have equal needs. Equal distribution of resources to every person is inappropriate when one considers individual health needs, autonomy, and total societal needs and resources. Thus, in terms of societal resources, this definition must be refined to refer to the equitable distribution of resources to all patients. By this is meant that all persons should have an equal opportunity to access resources which they rightly perceive as goods in pursuit of happiness. In other words, it is reasonable for persons in our communities, when experiencing illness or the threat of illness, to expect to have access to health care workers.

Faith-Based Care and Triage

The U.S. Department of Health and Human Services estimates that a pandemic could cause illness in ninety million Americans, and that ten million of them could require hospitalization. The department also estimates that in the first year of a pandemic, less than 10 percent of the population will receive an effective vaccine. Shortages of vaccines, antivirals, equipment, and supplies will be inevitable, necessitating rationing of health care.[37] Most important, the strain on health care workers will be significant. It is well documented that the nursing shortage will take years to reverse.[38] Also, between 1970 and 1999, the number of public health workers in every federal health district declined.[39] It is important to identify, in advance, the providers of non-

[36] Marie T. Hilliard, "The Identification of Nursing Ethics Content and Teaching Strategies for Baccalaureate Nursing Curriculum through Policy Delphi" (Ph.D. diss., University of Connecticut, 1986), 174.

[37] Hastings Center, "Flu Pandemic and the Fair Allocation of Scarce Life-Saving Resources," bioethics background paper, September 12, 2006, 1, 2, http://www.thehastingscenter.org/pdf/flu_pandemic_and_the_fair_allocation_of_scarce_life_saving_resources.pdf.

[38] Tri-Council Members for Nursing, "Strategies to Reverse the New Nursing Shortage," American Association of Colleges of Nursing position statement, January 2001, http://www.aacn.nche.edu/Publications/positions/tricshortage.htm.

[39] Center for Health Policy, Columbia University School of Nursing, "The Public Health Workforce Enumeration 2000," Bureau of Health Professions, National Center for Health Workforce Information and Analysis, December 2000, ftp://ftp.hrsa.gov//bhpr/nationalcenter/phworkforce2000.pdf.

governmental health care services. The largest such provider in the United States is the Catholic Church. In response to societal obligations, each Roman Catholic diocese in the United States has adopted the *Ethical and Religious Directives for Catholic Health Care Services.* These directives state, "Catholic health care ministry seeks to contribute to the common good. The common good is realized when economic, political, and social conditions ensure protection for the fundamental rights of all individuals and enable all to fulfill their common purpose and reach their common goals."[40] This means protecting the fundamental rights of all persons, includes employees.

Faith-based providers have obligations within a society. In the event of an anticipated pandemic, faith-based providers must be prepared for the following realities: (1) staff shortages due to the tensions between the need of health care workers to work to support their families and their need to protect their families from the virus; (2) staff refusals to report to duty either out of indolence or legitimate concerns, such as fear, real sickness, or governmental policy; (3) the need to create work opportunities such as working from home, provision of protective equipment, and child care if schools are closed; (4) staff who report to work showing signs of illness, and staff refusal of medical treatment for fear of getting sicker; (5) provision of supplies like food and water; and (6) the possibility of quarantines or forced social distancing.[41] However, these realities must be anticipated by all providers, not just faith-based providers. Furthermore, these realities will be compounded by the fact that studies indicate that a substantial number of health care workers will not come to work during a pandemic. Thus, the rationing of personnel also is inevitable.

Triage, the concept of determining who will live when not all can live, involves the rationing of scarce resources, including health care workers.[42] Options for such rationing in a pandemic that have been proposed as ethical include (1) prioritizing to prevent new infections (reserving vaccines and antiviral drugs); (2) prioritizing to protect essential medical and scientific personnel (with specialized training and a duty to care); (3) prioritizing the health and safety infrastructure (delineating the obligations of those workers who have been prioritized, above); (4) prioritizing patients or populations with the greatest medical needs, including use of age-based criteria (a controversial determinant[43] that is not accepted by this author, although an overall-health criterion, based on a patient's ability to benefit from care, is accepted); (5) prioritizing patients or populations who are chronically underserved (reflecting fairness in the application of actions); (6) prioritizing early detection and global response methods (cognizant that

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[40] U. S Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, 4th ed. (Washington, D.C.: USCCB, 2001), part one, intro.

[41] Hamilton County Pandemic Influenza Faith Advisory Committee, "Pandemic Flu Planning for Faith Communities" (Hamilton County, OH: General Health District, October 2006), available from Hamilton County Public Health.

[42] Hastings Center, "Flu Pandemic," 2.

[43] In fact, some hold that priority might be given to older persons and children, due to their higher risk of developing complications. See Channing Bete, "How You Can Be Prepared," 11.

a new pandemic will have a disproportionate effect on the poorest of the world); and (7) prioritizing provisions for transparency and public cooperation (fostering trust and compliance with allocation plans).[44] Options 2 and 3, above, are the heart of the matter in this essay. While health care workers can claim a right to access scarce resources such as vaccines and antiviral drugs to minimize an acknowledged risk to their own health, at the same time they have an obligation to provide services to the community that justify their access to these limited resources. Thus, professional codes of ethics that provide for a subjective analysis of such risks would appear to provide for rights without corresponding obligations.

Heroism and Virtue

The question that remains is whether historic professional heroism will prevail in the face of varying perceptions concerning the duty of health care workers to care? Legal liability provisions are framed in the context of an existing professional–patient relationship, which is not the usual preexisting scenario in a pandemic. Legal mandates in state practice acts are vague at best. As stated earlier, professional codes of ethics provide for subjective analyses of rights and obligations by the professional. Ethical theories, the analytical methods of philosophical reasoning, vary greatly in their approaches. Therefore, one is left with the natural moral law, either of Aristotle or Aquinas, also known as the "ethic of the good": "The grasping of the fundamental precepts of the natural moral law, whether undertaken theologically within the realm of faith, or outside it, comes about through the intuition of the *instinctus rationis* that perceives the ordering of nature toward that which is most appropriate to it."[45] The virtuous person acts reasonably by acting on behalf of ends perceived as goods in pursuit of happiness.

The virtuous person would report to duty in a pandemic because it is virtuous to serve others in need. He or she would be acting on behalf of an end, which is the health of the community, perceived as a good in pursuit of happiness. This good is a function of happiness, because we are members of this same community whose health we are protecting. This same virtuous person also would act reasonably in assuming duties. Thus, while the health care worker has an obligation to report to duty, allocation of responsibilities while on duty is to be consistent with the abilities and other obligations of the health care worker. At the same time, the reasoning person would recognize that all of society is at risk, including themselves and their loved ones, if the pandemic is not contained. A reasonable person would recognize that in serving society one is serving oneself and one's family. Thus, there is one duty throughout: a duty to care for oneself, one's family, and society.

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[44] L. O. Gostin, "Medical Countermeasures for Pandemic Influenza: Ethics and the Law," *Journal of the American Medical Association* 295.5 (February 1, 2006): 554–556.

[45] Wojciech Giertych, O.P., "New Prospects for the Application of the Natural Moral Law," address at the International Congress on the Natural Moral Law, Rome, February 14, 2007, in "Address of Papal Theologian on Natural Moral Law," *ZENIT*, February 24, 2007, http://www.zenit.org/article-19001?l=english.