

# Ethical Dilemma for a Medical Resident: A Case Study Analysis

M J Lee, A Maheshwari, P A Clark

## Citation

M J Lee, A Maheshwari, P A Clark. *Ethical Dilemma for a Medical Resident: A Case Study Analysis*. The Internet Journal of Infectious Diseases. 2016 Volume 15 Number 1.

DOI: [10.5580/IJME.43056](https://doi.org/10.5580/IJME.43056)

## Abstract

Ebola is a deadly disease with no cure; there is no vaccine developed yet. Many died during the 2014 outbreak in West Africa, and many healthcare professionals went to the virus infected area to treat the patients while placing their lives in danger. Not every medical professional placed in the field is a fully trained specialist, and sometimes one or two under-trained doctors are in charge of the entire clinic with some nurses and operating technicians. When unexpected outbreaks of the virus occur in the places, the doctor(s) would encounter medical and ethical dilemmas. Should they leave or stay? In fact, this dilemma is not confined to the Ebola pandemic but relevant to all similar cases. In this paper, three authors, a medical resident, a clinical bioethicist, and a theoretical bioethicist respond to the dilemma.

## INTRODUCTION

Ebola is a deadly disease with no cure. After the outbreak in West Africa in 2014, we have learned more about this disease but there is still much more we need to learn until a vaccine can be developed. The 2014 Ebola outbreak that occurred in Sierra Leone, Liberia, and Guinea killed thousands of people, and once the virus spread to the United States and terrified the US population. The Ebola-infected developing countries lacked the resources to provide care for their citizens and to protect those uninfected. Even the United States failed in many ways to address this deadly disease. Universal standard precautions are known to help prevent most transmissions through exposure to blood and body fluids, but these precautions demand necessary equipment that was not available in these developing nations. Personal protective equipment to avoid direct contact with blood and body fluids is expensive, and environmental controls were not even developed, let alone implemented. Accordingly, healthcare professionals treating these infected patients in these developing countries were placing their lives in danger. Then, the medical ethical question is: "Should they be ready to place themselves in harm's way?"

Many healthcare professionals treated infected Ebola patients and many of them died due to a lack of proper personal protective equipment. We also know that not all

medical professionals placed in the field are fully trained specialists. Plus, unexpected outbreaks of the virus occur in the places where no trained personnel are present. Then, the question is, "What should the under-trained healthcare workers do when they encounter the unexpected outbreak, especially when the situation is medically dire, e.g., not enough personal protective equipment?" Is it ethically justifiable for them to abandon the infected patients and leave? This paper is a composite of ethical analytic responses to such a case.

Suppose that a second year medical resident married with two children whom we shall call "Dr. A" volunteered to spend a month in Sierra Leone for a rotation in international public health medicine. In a clinic with one staff physician, ten nurses, and some other operating staff members, he finds himself as the one in charge of the clinic by replacing the staff physician. Then, the Ebola virus suddenly breaks out panicking everyone in the clinic and Dr. A is unable to contact the staff physician enjoying his vacation 500 miles away. Dr. A remembers the Hippocratic Oath he took that he would hold a special medical obligation for those infirm. However, the dire circumstance he encounters places him in the ethical dilemma, whether he should stay with the infected patients or leave.

Authors of this paper make a three-part analytic commentary

on this case. The first section, "From the Perspective of a Medical Professional" is a response from a third-year medical resident. The following section, "From the Perspective of a Clinical Bioethicist," is the view of a seasoned clinical bioethicist and theologian. Last, "From the Perspective of a Theoretical Ethicist," is opined by a philosopher whose primary research interest is in theories of medical ethics.

### THE CASE

As a second year medical resident at Mercy Catholic Medical Center, Dr. A decided to do a one-month rotation in international public health medicine in the Sierra Leone. Dr. A is married with two small children but his family agrees that this rotation would help his long-term career goals. Dr. A was assigned to a remote clinic in central Sierra Leone. The clinic had a staff of one physician, ten nurses, fifteen medical technicians and twenty auxiliary staff members. The clinic serves as a mini-hospital with 35 in-patient beds. The staff physician was very grateful to have Dr. A for a month so he could take a much needed vacation. In the second week at the clinic Dr. A had a patient present with fever, headache, joint and muscle aches, sore throat, and weakness, followed by diarrhea, vomiting, and stomach pain. A rash, red eyes, hiccups and internal and external bleeding was seen in the patient. Immediately the staff became quite concerned and informed Dr. A that the patient appeared to have the Ebola virus. Dr. A was unfamiliar with the Ebola virus and began doing an immediate search of the symptoms and the condition. He learned the following:

- a. Infections with Ebola virus are acute. There is no carrier state. Because the natural reservoir of the virus is unknown, the manner in which the virus first appears in a human at the start of an outbreak has not been determined. However, researchers have hypothesized that the first patient becomes infected through contact with an infected animal.
- b. After the first patient in an outbreak setting is infected, the virus can be transmitted in several ways. People can be exposed to Ebola virus from direct contact with the blood and/or secretions of an infected person. Thus, the virus is often spread through families and friends because they come in close contact with such secretions when caring for infected persons. People can also be exposed to Ebola virus through contact with objects, such as needles, that have been contaminated with infected secretions.
- c. Nosocomial transmission refers to the spread of a disease within a health-care setting, such as a clinic or hospital. It

occurs frequently during Ebola hemorrhagic fever (Ebola HF) outbreaks. It includes both types of transmission described above. In African health-care facilities, patients are often cared for without the use of a mask, gown, or gloves. Exposure to the virus has occurred when health care workers treated individuals with Ebola HF without wearing these types of protective clothing. In addition, when needles or syringes are used, they may not be of the disposable type, or may not have been sterilized, but only rinsed before reinsertion into multi-use vials of medicine. If needles or syringes become contaminated with the virus and are then reused, numerous people can become infected.

Dr. A learned that there is no standard treatment for Ebola HF. Patients receive supportive therapy. This consists of balancing the patient's fluids and electrolytes, maintaining their oxygen status and blood pressure, and treating them for any complicating infections. 90% of all infected patients die.

The staff members at the clinic became very alarmed and were fearful that they would become infected. Many refused to treat the patient for fear of becoming infected. Within 48 hours there were 15 patients now infected with the Ebola Virus. Dr. A was unable to contact the staff physician who was 500 miles away and did his best to notify authorities of the outbreak. Within 72 hours one of the staff nurses became infected and the majority of the staff was in the process of abandoning the clinic. Dr. A contacted his colleagues back in the States and many advised him to leave the DRC immediately for fear of becoming infected with the result being death.

Dr. A was now in an ethical and medical dilemma. He had taken the Hippocratic Oath that states "I will remember that I remain a member of society, with special obligations to all my fellow human beings, those sound of mind and body as well as the infirm."<sup>1</sup> He was also the only medical physician available and to leave under these conditions could be considered patient abandonment. However, there is no cure for the Ebola virus, Dr. A is not adequately trained in infectious diseases, and the odds seem very high that if he stays he will become infected and there is a high probability that he could die. Dr. A also has his family to consider. The clinic has now been isolated and only patients with the Ebola virus are in the clinic. The staff is running low on medications and the World Health Organization (WHO) has been notified but the staff is unsure when they will or if they will arrive to assist them. The local villagers have abandoned the village and the staff is decreasing in number. To date they have 30 patients and there have been 10 deaths. If you

were Dr. A, what would you do in this situation? Should the staff be placed in medical jeopardy or removed for their own safety?

### FROM THE PERSPECTIVE OF A MEDICAL PROFESSIONAL

**Medical Investigation.** A recommendation of what Dr. A should do from a medical professional's perspective should be preceded by an understanding of the medical facts about the Ebola virus. The Ebola is an RNA virus which is a member of the family Filoviridae. It was previously known as a hemorrhagic fever virus due to the clinical conditions it caused; however, it is now known as Ebola virus disease.<sup>2,3</sup> The Ebola virus is divided into five species (Zaire, Sudan, Ivory Coast, Bundibugyo, and Reston)<sup>4</sup> the first four of which can cause disease in humans. According to records, its outbreaks occurred in Democratic Republic of the Congo in 1995, Uganda in 2000, and West Africa in 2014-2015.<sup>5</sup> And approximately 28,500 suspected and laboratory-confirmed cases attributed to the Ebola were filed, among which there were more than 11,000 deaths.<sup>6</sup> In this particular case, 60% of the 881 infected healthcare workers died.<sup>7</sup> In the U.S., the first Ebola case was reported in September 2014 in Dallas, Texas, and the patient died.<sup>8</sup>

Data has suggested that bats are possible viral reservoirs of the Ebola virus in Africa.<sup>9</sup> A human person can be infected through contact with meat or body fluids of an infected animal. After the person is infected, the virus spreads through direct contact via any type of body fluid or even skin contact. Data from World Health Organization (WHO) suggests that the most infectious body fluids include blood, feces, and vomitus, although the virus has been detected in all other body fluids as well, including urine, saliva, sweat, semen/vaginal fluid, tears, and breast milk.<sup>10</sup> Follow-up studies done on survivors from previous outbreaks show that the infectious virus can be present in body fluids though not detected in blood, which makes it possible that the transmission of the virus occurs many months before we even know it.<sup>11</sup>

The Ebola's incubation period varies between two to 21 days.<sup>12</sup> Affecting many systems of human body, the virus' initial symptoms are nonspecific and include fever, chills, headache, vomiting, diarrhea and fatigue. And within a week of illness a diffuse nonpruritic, erythematous rash can develop. The gastrointestinal symptoms generally predominate and commonly lead to vomiting and diarrhea which may lead to hypovolemic shock. Some infected

patients develop minor bleeding such as petechiae, mucosal bleeding, and blood in the stools; however, gross bleeding is only seen at the terminal stage of the illness.<sup>13</sup> Patients can also develop an array of neurological symptoms including altered mental status, stiff neck, seizures, blurred vision, photophobia, vision loss.<sup>14</sup> Laboratory abnormalities include leukopenia, thrombocytopenia, abnormal hematocrit, transaminitis, elevated PT/INR, increased BUN/creatinine, and multiple electrolyte disturbances.<sup>15</sup> Complications such as septic and hypovolemic shock, acute kidney failure, respiratory failure, DIC, and liver failure can occur, which usually results in death of these patients within two weeks. For the Ebola survivors, the recuperative period persists more than two years while causing many chronic conditions and disabilities such as arthralgias, ocular symptoms, skin and hair loss, and failure to thrive.<sup>16,17</sup>

Diagnosis largely depends on appropriate triage of the patient determined by the concerning signs and symptoms, level of risk of exposure, and time of exposure. Center for Disease Control and Prevention (CDC) defines the level of risk into four stages: high risk, some risk, low risk, and no identifiable risk.<sup>18</sup> And based on the categories, the patients are divided into symptomatic or asymptomatic. Clinical judgment and circumstantial evidence is of utmost importance. If a patient has travelled to an infected area within 21 days of the onset of nonspecific symptoms or had contact with a person diagnosed with Ebola, the index of suspicion should be high. A laboratory diagnosis of Ebola is made by detection of viral antigens or RNA in body fluid. Viral RNA can be detected within three days of the symptom's onset. A reverse-transcription polymerase chain reaction for the Ebola virus infection should be done only in patients who have symptoms concerning for the Ebola, with any possible risk of exposure.<sup>19,20</sup>

Based on the guidelines from the WHO and CDC, those suspected to have Ebola infection should be isolated immediately. The use of personal protective equipment, infection control precautions, and involvement of infection control staff should be initiated promptly by all healthcare workers.<sup>21</sup> There are no approved medications for the treatment or for post-exposure prophylaxis of Ebola virus infection. Many experimental anti-viral agents were used in the outbreaks; however, their efficacy is not clearly understood and still being studied. And there are no approved vaccines to prevent the virus yet. Therefore, the mainstay of treatment for Ebola virus infection is supportive care.

The major focus of the healthcare professions is to provide adequate fluid resuscitation so that hypovolemic shock and electrolyte abnormalities may be prevented due to excessive GI losses. Other types of supportive care known to be beneficial include anti-emetic, anti-diarrheal, anti-pyretic, analgesic, anti-epileptic medications and blood products. Mechanical ventilation for respiratory support may be required if pulmonary edema or acute lung injury ensue. Also, empiric antimicrobials, parenteral nutritional support, and renal replacement therapy may be required in later stages.

**Other Term of Hippocratic Oath.** Now, what should or would Dr. A do? First of all, Dr. A is not an infectious disease specialist, a trained emergency medical physician, or a critical care physician who will be able to deal with patients of such acuity. He is a medical resident. While he was in the clinic, within 48 hours 15 patients got infected with the Ebola virus and in 72 hours one of the staff nurses became infected as well. This clearly shows that Dr. A is unable to control the situation or protect his staff and other patients, since he does not have the required skills. Dr. A may refer to his vow to the Hippocratic Oath which demands that he has special obligations to care for his fellow human beings who are ill. However, he should be reminded of the part of the Hippocratic Oath that states, "I will not be ashamed to say 'I know not,' nor will I fail to call in my colleagues when the skills of another are needed for a patient's recovery."<sup>22</sup> Although he is the only physician available in the area, Dr. A is not qualified to handle this particular disease. Perhaps due to lack of his knowledge and training, Dr. A did not immediately isolate the initial infected patient, particularly among his staff members, the fact of which is contributed to the virus' further spread. Besides, the clinic is already short on medications for supportive care, does not have personal protective equipment, and has minimal infection control methods available at this time. Due to the nature of the disease shown above and to its time sensitivity, it is best that Dr. A should leave immediately and be replaced with a seasoned physician who is trained to handle the situation. He should contact the authorities and request for the current patients to be transferred from this community care center to a better equipped Ebola treatment center; many of which may have been established in areas across West Africa.

**Harm-Benefit Analysis.** In addition, when risks are high and treatment benefits low, physicians should make their own decisions without being obligated by "duty." All

physicians have a right to their own safety first, because healthcare providers cannot be useful if they turn into patients themselves. It is important to protect themselves first to be able to help others. Putting one's own life at risk, when the physician is not contributing positively, is not advisable. Thus, Dr. A should leave immediately. Also, each staff member should be asked to decide whether they would like to stay or leave for their own safety.

### FROM THE PERSPECTIVE OF A CLINICAL BIOETHICIST

**Respect for Person.** From the perspective of a Clinical bioethicist. To examine this case from a practical-clinical ethical perspective, the ethical principles of respect for person's life, beneficence/nonmaleficence, and justice are invoked. First, the respect for person's life ("respect for person" henceforth) refers to the right of a person to exercise self-determination and to be treated with dignity and respect. And the principle of respect for person demands two separate moral requirements: the requirement to acknowledge autonomy and the requirement to protect those with diminished autonomy.

Being a medical resident, Dr. A is not fully trained in infectious diseases. Also, he is not being supervised by an attending physician, at the moment, because the attending physician is away on a break. In addition, he seems to exhibit impediments to his will and intellect which include fear, vincible and invincible ignorance, coercion, etc. He does not have the proper personal protective equipment to protect himself and his medical staff from potential exposure to blood and body fluids. That being so, though no one can say that Dr. A had the "right" to protect his own health and life, it might be argued that respect for person would dictate that he should do everything possible to protect his health and life and thus that he should leave immediately.

However, the problem is that his patients have diminished autonomy and are the most vulnerable of people. They have contracted a deadly disease that is 90% fatal. They are suffering without supportive therapies, and the medical resident is the only trained medical physician at the clinic. To leave these infected patients would be a form of abandonment and is a clear violation of a vulnerable person. Therefore, to leave violates a vulnerable person's human rights and the basic dignity and respect that every person deserves, thereby making it the violation of the principle of respect for person.

**Beneficence/Non-maleficence.** The principle of beneficence

involves the obligation to prevent, remove, or minimize harm and risk to others and to promote and enhance their good. Beneficence includes nonmaleficence, which prohibits the infliction of harm, injury, or death upon others. In medical ethics this principle has been closely associated with the maxim *primum non nocere* (“Above all, do no harm”). To abandon these vulnerable patients at a time when many are near death because the physician fears he might become infected is neither minimizing risks and harms nor promoting or enhancing the good. In the first place, there is a high probability that Dr. A himself may already be infected. Second, even if he does leave the clinic and heads to the capital, it is very unlikely that he will be able to return home. He would need to be evaluated and even be quarantined for an extended period of time. The direct intention of leaving the clinic without a physician will impact the patients in the clinic and will directly impact any further patients who are brought to the clinic in the following days and weeks. This would be a direct infliction of harm and injury on the patients in the clinic and further patients brought to the clinic. Failure to recognize this fact is a failure not only of the test of beneficence; it may also be a failure of the test of nonmaleficence.

**Justice.** The principle of justice recognizes that each person should be “given his or her due” which include treating people fairly and equitably. Dr. A could argue that leaving the clinic immediately would possibly save his life and thus he would have the potential to help many patients in the future as a physician. Besides, left alone at the clinic unsupervised and not being adequately trained to handle this outbreak of Ebola, he would argue that he has not been treated fairly and equitably. He may argue as well that he has a responsibility for his own life and a responsibility to his immediate family. Accordingly, to stay and risk his life, under the present circumstances, would be neither fair nor equitable.

However, seeking justice in the way of considering a physician’s own life and wellbeing against those of the patients the physician cares for is not the type of ethical reasoning that most ethicists would accept. Nevertheless, given the circumstances, it is possible to conceive the justice Dr. A may appeal to here as a concern of “giving him his due.” But saying that justice is giving each person what he or she deserves and that this is what Dr. A demands does not help us much understand the concrete meanings of justice involved here.<sup>23</sup> How do we determine what Dr. A deserves? What criteria should we use to determine what is due to Dr.

A? To answer these questions seems to require an agreement on the moral identity of a medical profession at the fundamental level, which cannot be treated here. Thus, while admitting that Dr. A can resort to justice in accordance with his desert, we will not proceed to elaborate its content.

**Slippery Slope.** There is also a concern for the slippery slope. In a slippery slope argument, a course of action is rejected because, with little or no evidence, one insists that it will lead to a chain reaction resulting in an undesirable end or ends. If Dr. A is permitted to abandon his patients because of fear that he might contract this deadly disease, what will stop physicians from abandoning their patients when other epidemics break out in the future? We cannot forget HIV/AIDS, Bird Flu, SARS, Middle East Respiratory Syndrome, Zika, etc.,. Once a precedent is established, it logically follows that it can become applicable to other related situations.

**Balancing.** Physicians have an ethical obligation to use their knowledge of medicine and their medical skills fairly and to distribute them equitably. Failure to do so is ethically irresponsible and morally objectionable. To compromise the basic ethical foundations upon which medicine stands is destructive not only for the medical resident and his patients at the clinic but to society as a whole. To decide what Dr. A should do ethically in this situation, we must balance Dr. A’s best interest as a physician (possible justice) with the best interest of his patients and society as a whole (respect for person and beneficence/non-maleficence) and its relevant moral concern (slippery slope) against the backdrop of the given context: the medical knowledge we have about the Ebola virus, the lack of another physician, the lack of protective medical equipment against Ebola, the high possibility that Dr. A may already be infected and may not be able to return home, the fact that intentionally abandoning his patients would cause immediate death to those in the clinic and that he would not be available to assist others brought to the clinic for medical care, etc. And it seems clear that the medical resident must remain at the clinic and take care of his patients, while continuing to contact trained medical professionals at the CDC and WHO to let them aware of the situation and to request more medical personnel and protective medical equipment.

### FROM THE PERSPECTIVE OF A THEORETICAL ETHICIST

#### The Principle of Special Medical Obligation [PSMO].

The general moral principle which applies to our case is the

Hippocratic moral oath that Dr. A took. By taking the vow, he voluntarily forfeited the right to the minimal morality of an ordinary citizen and bound himself as a doctor to a more stringent kind of medical morality, one term of which says: "I will remember that I remain a member of society, with special obligations to all my fellow human beings, those sound of mind and body as well as the infirm." Dr. A is also bound to another term of the oath, "I will not be ashamed to say 'I know not,' nor will I fail to call in my colleagues when the skills of another are needed for a patient's recovery." However, the two terms do not seem to contradict with each other, nor do they suggest that Dr. A should leave or stay in this particular situation. Whereas the former term enjoins that doctors should hold a special medical obligation both to those who are sound and infirm, the latter calls for professional humility. To be precise, the latter is not relevant in our context because exercising professional humility is what Dr. A can do with or without leaving the clinic. In other words, Dr. A can inform the trained medical professionals at CDC and WHO that he is not capable of handling the situation because of his lack of knowledge and training, regardless of change of his physical location. On the other hand, it is not entirely clear if the former term dictates that Dr. A should stay or leave. Thus, this will be the focus of our investigation in the following.

Let us say that the former term of the oath is the ethical principle of special medical obligation (PSMO). In an ordinary clinical medical setting, not treating a patient intentionally or out of negligence is the violation of the PSMO, which in turn is the violation of its narrower or specified principles, that is, the principles of beneficence/non-maleficence and of respect for person. And it is possible to say that the same moral reasoning applies to our case. Since healthy people do not need doctors, the PSMO that apply both to those sound and infirm is de facto relevant only to the sick. Therefore, Dr. A has a special obligation to care for the infected and thus should not leave the clinic.

Nevertheless, it is still not clear that Dr. A's case can be treated in this manner. Given that this is a dire circumstance in which the physician's own life is in danger (let alone that the situation may be the case of practical futility), it can be said that Dr. A should not leave only when the PSMO's moral binding power extends to the point that doctors should be ready to risk their own lives to care for the sick. To examine this, we should move to the understanding of the concept of supererogation.

**Supererogation.** Supererogation refers to the act that goes beyond what is considered a call for ordinary moral duty. Thus, supererogation is typically called the "morality of saints or heroes" though the agents of supererogatory acts may not think of their deeds as saintly or heroic. Given now that risking physicians' own lives to care for the infected patients in the case of practical futility is a supererogatory act, the question is whether or not the PSMO includes the moral binding force of supererogation, to say that Dr. A should stay.

Traditionally, supererogation was discussed as a theological subject. And in the sixteenth century Europe, the Roman Catholic doctrine of supererogation, opera supererogationis, aroused a heated theological debate between the Roman Catholic theologians and the Protestant reformers.<sup>24</sup> In accordance with the tradition left by the Early Church Fathers, the Catholics believed that supererogation did exist as they form the two evangelical counsels of the New Testament (i.e., chastity as celibate lifestyle and obedience as monastic vows) as supererogatory while considering ordinary Christian life (e.g., taking a wife, owning private properties, etc.) no sin.<sup>25</sup> Meanwhile, the Protestant Reformers, Luther, Calvin, Anglican theologians, fiercely opposed opera supererogationis because they did not believe the theory of super-meritorious acts. They argue that no human beings, not even saints, can go beyond what ordinary morality is required. In other words, there cannot be morality beyond morality. In a fundamental level, the Protestant opposition to supererogation has to do fundamentally with their doctrine of soteriology. In Protestantism, salvation is not by works but by Grace alone, so it is absurd to focus on what "ethical works" human beings can do.<sup>26</sup>

**Three Versions of Supererogationism.** The two theological views on supererogation are further developed in contemporary analytic philosophy. The philosophers like David Heyd (1982) and J. O. Urmson (1988) are known to be primary figures who initiated the philosophical discussion of supererogation. We introduce here three philosophical positions on supererogation by following Heyd's category: Anti-supererogationism, unqualified supererogationism, and qualified supererogationism. Anti-supererogationists, whose view is aligned with that of the Protestant theologians, claim that there is no such thing as supererogatory morality because there cannot be greater or lesser morality. The essence of morality is absolute and universal. And Emmanuel Kant's deontological ethics nicely fits in with this idea; it is no wonder that Kant himself was a Lutheran.<sup>27</sup>

On the other hand, unqualified supererogationists acknowledge the existence of two distinct moralities: one is ordinary and the other, supererogatory. Supererogatory acts, unlike ordinary moral acts, are “characterized as purely voluntary, optional, and in a sense arbitrary, that is, not determined by universal standards or rules.”<sup>28</sup> Underlying this idea is the view that “human beings are autonomous individuals having a basic right . . . [t]heir duty is limited and moral.”<sup>29</sup>

However, the most serious problem with both anti-supererogationism and unqualified supererogationism which is relevant to our case (let alone other theoretical problems) is the difficulty of finding criteria whereby actual cases can be judged to be morally obligatory, recommended, or not.

From the standpoint of anti-supererogationism, supererogation cannot be invoked when the PSMO applies because there is no such thing as supererogation. Then, for example, anti-supererogationists may argue that, under the binding power of one and the only morality, the PSMO dictates that Doctor A should stay to treat the dying patients. Doctor A does not become a hero or saint to act in obedience to the vow to the PSMO he made. It is just the demand of ordinary morality; otherwise, he should not have become a medical doctor. However, anti-supererogationists can produce the opposite moral verdict by appeal to the same morality. They can support Doctor A’s withdrawal by saying that there is no such morality that demands for Doctor A to risk his own life. The PSMO does not demand such an act. The only morality that applies to this case, they may say, is the negative Golden Rule: “Do not do unto others what you do not want others to do unto you.” Since no one wishes to risk one’s own life, others cannot expect Doctor A to stay to risk his own life in the name of morality.

The same type of problem exists in unqualified supererogationism. It is not only that unqualified supererogationism cannot propose whether the PSMO should include the sense of supererogation or not, but also that, even if it does, its two-tier structure itself does not produce practical guidelines to evaluate whether Doctor A’s decision to stay can be viewed supererogatory or not. Suppose that the PSMO demands supererogation. Given that a supererogatory act is praiseworthy but not obligatory, Doctor A’s decision to stay may be viewed either as a praiseworthy, supererogatory act; or to fall into the class of foolhardy and irresponsible acts, the act to risking his own life and putting his family in the expected misery. One can say that Dr. A may have already been infected and there is a

high chance that he may not be able to return home for an extended period of time even if he survives and thus that Dr. A’s decision to stay cannot be a foolhardy act. However, this view makes the medical resident’s act look as if his decision to stay were out of despair or “nothing-to-lose” attitude, thereby making his act not entirely praiseworthy. After all, unqualified supererogationism, problematically, makes its criteria widely open to the interpretations of those who evaluate the act.

The last category is qualified supererogationism. This position seems to offer the most reasonable responses to the moral struggle that Doctor A is facing. Conceiving supererogatory acts to exist in unqualified sense is problematic for the aforementioned reason. Completely denying the existence and value of supererogatory action does not fit with most people’s intuition. Thus, supererogation should exist. Qualified supererogationism is an attempt to account for its legitimacy without the problem of unqualified supererogationism by distinguishing between different kinds of moral duties and specifying conditions and limits of the application of the duties. Since this is the most popular view of supererogationism found in academic literature, there are many variations of it. The most popular and traditional kind of qualified supererogationism is found in the Catholic theological tradition’s doctrine of opera supererogationis.<sup>30</sup> As alluded above, this view classifies people into those who can take up saintly morality and those for ordinary morality. These different groups of people are sometimes justified to hold different “vocations.” The qualified supererogationism says that, in a fundamental level, supererogatory morality is required. However, for the vast majority of people, due to their frail moral nature, the supererogatory moral obligation is excused. On the other hand, only for those blessed with the strength of character and virtue, supererogatory morality is required.

Critics may say that the major problem of this view is that it is “subjectivist” in the sense that the individual decides what to do. There cannot be an objective standard to say that a certain action is supererogatory and required for a certain group of people. Nevertheless, this problem is not the same kind of systemic ambiguity problem that anti-supererogationism and unqualified supererogationism hold. While the first two theories cannot produce a practical moral verdict about an actual case both in the first-person and third-person levels, qualified supererogationism demands that the decision is made primarily from the first-person view. Therefore, there is no ambiguity within its system.

Qualified supererogationism does not suggest that the PSMO should include the supererogatory component or not. However, this is not a theoretical vice but merit, for it is unnecessary for this view to discuss its possible theoretical underpinnings vis-a-via the PSMO. The theory says that an individual moral agent, whether the agent is a medical doctor or not, decides how much he or she can do based on the agent's own moral capacity. In our case, Dr. A should reason whether he is called to the saintly duty to stay with the dying patients though it may mean to risk his own life. He may interpret that the PSMO he is committed to the essential part of his God-given vocation as a medical doctor. He may understand that the situation he is facing now is practically futile; however, leaving the patients is abandoning them and thus forsaking the oath he took. He may ponder how his wife and children may suffer in case he could not make it through. However, he may believe in miracles and think to himself that the Almighty can take better care of them than he might. Thus, it is better for me to die here than to live unfaithfully with the broken vow, he may conclude.

The critics of qualified supererogationism may say that Dr. A's decision cannot be justified because, given that the situation is the case of practical futility, his decision is irrational. Thus, Dr. A's decision to stay cannot be justified in terms of any type of morality. However, this criticism opens a controversial, perennial debate that not many philosophers and theologians wish to engage in. When the agent's moral decision is criticized on the basis of a rational standard, does the philosophical proof of burden is upon the critics, such as "Does the criticism presuppose that morality is part of rationality just like the Kantian deontological scheme?" "If morality should be sanctioned by rationality, then what are the criteria of rationality that make morality, moral?", etc.<sup>31</sup>

Qualified supererogationism of the traditional kind seems the most plausible theory of supererogationism. However, being a subjectivist ethical view, qualified supererogationism makes the third-party recommendation not significant or even relevant, though this cannot be a theoretical or practical problem. Accordingly, we, as medical professionals committed to the same vow and as Dr. A's (imaginary) colleagues who are genuinely concerned about his and his families' wellbeing, may say like this, "Hey Doc, you should leave immediately. But, if you decided to stay to care for the dying patients, it would really be admirable."

## References

1. "Hippocratic Oath, Modern Version," Sheridan Libraries of Johns Hopkins University, last updated June 1, 2016, accessed July 12, 2016, <http://guides.library.jhu.edu/c.php?g=202502&p=1335759>
2. M. Bray, "Pathogenesis of Viral Hemorrhagic Fever," *Current Opinion in Immunology* 17 (2005):399.
3. S. Mahanty and M Bray, "Pathogenesis of Filoviral Haemorrhagic Fevers," *The Lancet Infectious Disease* 4 (2004): 487.
4. Bray M. Filoviridae. *Clinical Virology*, ed. DD Richman, R J Whitley, and F G Hayden (ASM Press: Washington DC, 2002), 875.
5. H. Feldmann H, T. W. Geisbert, "Ebola 'Haemorrhagic Fever,'" *Lancet* 337 (2011): 849.
6. "Ebola Situation Report - 11 November 2015," World Health Organization (WHO), accessed July 2, 2016, <http://apps.who.int/ebola/current-situation/ebola-situation-report-11-november-2015>.
7. Ibid.
8. "First Imported Case of Ebola Diagnosed in the United States," Centers for Disease Control and Prevention (CDC), accessed July 3, 2016, <http://www.cdc.gov/vhf/ebola/outbreaks/2014-west-africa/united-states-imported-case.html>.
9. E. M. Leroy et al, "Human Ebola Outbreak Resulting from Direct Exposure to Fruit Bats in Luebo, Democratic Republic of Congo 2007," *Vector-Borne and Zoonotic Diseases* 9 (2009): 723.
10. "What We Know about Transmission of the Ebola Virus among Humans," WHO, accessed July 3, 2016, <http://www.who.int/mediacentre/news/ebola/06-october-2014/en/>.
11. A. K. Rowe et al, "Clinical, Virologic, and Immunologic Follow-Up of Convalescent Ebola Hemorrhagic Fever Patients and Their Household Contacts, Kikwit, Democratic Republic of the Congo, Commission de Lutte contre les Epidémies à Kikwit," *Journal of Infectious Disease* 179 (1999): Supplement 1, S28.
12. J. S. Schieffelin et al, "Clinical Illness and Outcomes in Patients with Ebola in Sierra Leone," *New England Journal of Medicine* 371 (2014): 2092.
13. "Ebola Virus Disease Information for Clinicians in U.S. Healthcare Settings," CDE, accessed July 4, 2016, <http://www.cdc.gov/vhf/ebola/hcp/clinician-information-us-healthcare-settings.html>.
14. B. Kreuels et al, "A Case of Severe Ebola Virus Infection Complicated by Gram-Negative Septicemia," *New England Journal of Medicine* 371 (2014): 2394.
15. L Hunt et al, "Clinical Presentation, Biochemical, and Haematological Parameters and Their Association with Outcome in Patients with Ebola Virus Disease: an Observational Cohort Study," *Lancet Infectious Disease* 15 (2015): 1292.
16. D. V. Clark et al, "Long-Term Sequelae after Ebola Virus Disease in Bundibugyo, Uganda: a Retrospective Cohort Study," *Lancet Infectious Disease* 15 (2015): 905.
17. J. G. Mattia et al, "Early Clinical Sequelae of Ebola Virus Disease in Sierra Leone: a Cross-Sectional Study," *Lancet Infectious Disease* 16 (2016): 331.
18. "Epidemiologic Risk Factors to Consider When Evaluating a Person for Exposure to Ebola Virus," CDC, accessed July 5, 2016, <http://www.cdc.gov/vhf/ebola/exposure/risk-factors-when-evaluating-person-for-exposure.html>.
19. "Interim Guidance for Specimen Collection, Transport, Testing, and Submission for Patients with Suspected



- Infection with Ebola Virus Disease,” CDC, accessed July 8, 2016, <http://www.cdc.gov/vhf/ebola/pdf/ebola-lab-guidance.pdf>.
19. Ibid.
20. “Infection Prevention and Control Recommendations for Hospitalized Patients with Known or Suspected Ebola Hemorrhagic Fever in U.S. Hospitals,” CDC, accessed July 9, 2016, <http://www.cdc.gov/vhf/ebola/hcp/infection-prevention-and-control-recommendations.html>.
21. “Hippocratic Oath, Modern Version.”
22. Given that justice means “giving each person what he or she deserves” or in a more traditional sense “giving each person his or her due,” justice and fairness are the terms often used interchangeably today. Nevertheless, a technicality demands that justice is the term with reference to a standard of rightness while fairness is often associated with an ability to judge without reference to one's feelings or interests, or with the ability to produce judgments that are “concrete and specific to a particular case” [Manuel Velasquez et al, “Justice and Fairness,” *Issues in Ethics*, Vol 2/No. 2 (Spring 1990)]. Different kinds of justice are discussed in philosophical and theological literature. One is “distributive justice” as the term referring to the condition in which benefits and burdens are distributed among members in ways that are just and fair. Another is “procedural justice” which dictates that members should be treated justly and fairly in the processes which involve resource allocation, dispute resolution, administrative performance, legal proceedings, etc. Another is “corrective justice” (retributive or criminal justice) which refers to the state of affairs in which punishments for particular crimes are fair and just. The last would be “compensatory justice” refers to the state of affairs where just and fair compensations are made for injuries by those who have injured them. In medical ethics, the first two notions of justice, distributive and procedural justices are typically concerned.
23. David Heyd, *Supererogation* (Cambridge: Cambridge University Press, 1982), 15
24. Ibid.
25. Martin Luther, *Festival Sermons of Martin Luther*, trans. Joel Basely (Michigan: Mark V Publication, 2005), 68-69.
26. Traditional virtue ethicists also agree with anti-supererogationism because the ideal of virtues like prudence, courage, charity, etc. is open-ended. It is difficult to come up with any standard measures to determine, for example, how much prudence qualifies to be “ordinary prudence” or “supererogatory prudence.” On the other hand, classic utilitarianism which strictly adheres to the Bentham’s Maxim is understood anti-supererogatory in character, for there is no morality beyond practical applications of its single most important deontological-consequentialist principle, that is, the greatest pleasure for the greatest number.
27. Heyd, *Supererogation*, p. 9
28. Ibid.
29. Some modern accounts for qualified supererogation include the contract theorists’ version of supererogationism. They believe that supererogatory morality is obligatory but should be considered something that ideal contractors agree not to enforce in society based on the overall harm-benefit analysis. It is simply not working when it applies to ordinary people in an institutionalized setting. Thus, failure to act in accordance with supererogation is blameworthy but should not be legally penalized. Supererogation is justified in this qualified way. See David Richards, *Theory of Reasons for Action* (Oxford: Clarendon Press, 1971).
30. Some authors argue that qualified supererogationism can be justified in the sense that supererogation is of moral reason contrary to rational reason of nonmoral kind. However, this position is subject to the similar kind of criticism we are discussing here. The distinction between morality and reason cannot be clear. Also, it is more problematic to widen the gap between morality and rationality. See Douglas Portmore “Position-Relative Consequentialism, Agent-Centered Options, and Supererogation,” *Ethics* 113 (2003): 303-332; Portmore, “Are Moral Reasons Morally Overriding?” *Ethical Theory and Moral Practice* 11 (2008): 369–388.

**Author Information**

**Marvin J. H. Lee, Ph.D.**

Bioethics Consultant Institute of Clinical Bioethics Saint Joseph's University  
Philadelphia, Pennsylvania

**Ana Maheshwari, M.D.**

Internal Medicine Resident Mercy Catholic Medical Center  
Darby, Pennsylvania

**Peter A. Clark, S.J., Ph.D.**

Director-Institute of Clinical Bioethics Saint Joseph's University  
Philadelphia, Pennsylvania