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Ethics in Times of Plague: Home Care, Obligations to Treat, End of Life, and Public Policies

Michael Woods Nash
University of Tennessee - Knoxville

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To the Graduate Council:

I am submitting herewith a thesis written by Michael Woods Nash entitled "Ethics in Times of Plague: Home Care, Obligations to Treat, End of Life, and Public Policies." I have examined the final electronic copy of this thesis for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Master of Arts, with a major in Philosophy.

Glenn C. Graber, Major Professor

We have read this thesis and recommend its acceptance:

John Hardwig, John Davis

Accepted for the Council:
Carolyn R. Hodges

Vice Provost and Dean of the Graduate School

(Original signatures are on file with official student records.)

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_John Hardwig_________

_John Davis___________

Acceptance for the Council:

_Anne Mayhew____________
Vice Chancellor and Dean of
Graduate Studies

(Original signatures are on file with official students records.)

ETHICS IN TIMES OF PLAGUE:
HOME CARE, OBLIGATIONS TO TREAT, END OF LIFE, AND PUBLIC POLICIES

A Thesis
Presented for the
Master of Arts
Degree
The University of Tennessee, Knoxville

Michael Woods Nash
August 2006

I had plague already, long before I came to this town and encountered it here….I have realized that we all have plague, and I have lost my peace….And I know, too, that we must keep endless watch on ourselves lest in a careless moment we breathe in somebody's face and fasten the infection on him….All I maintain is that there are on this earth pestilences and there are victims, and it's up to us, so far as possible, not to join forces with the pestilences….That's why I decided to take, in every predicament, the victim's side, so as to reduce the damage done.

Albert Camus
The Plague

Abstract

Almost exclusively, clinical bioethicists pose and answer questions in the context of day-to-day, medical practice in the West. This setting abounds with therapeutic procedures, drugs, and other resources to restore comfort and health to persons who suffer. In making moral judgments, we focus on patients, attend at times to their families, and—most rarely—consider the well-being of the rest of society as it is affected by particular treatment decisions.

Although this approach has resulted in a measure of moral progress with respect to our standard, clinical setting, it all but neglects the unique and compelling questions that arise in the context of an outbreak of a highly-virulent, infectious disease. In this setting—which I call the plague context—illness is acute, often violent and incurable, and persons who are infected necessarily pose a grave danger to those around them. In this paper, I examine a range of ethical questions in relationship to such an outbreak. Some of these questions are concerned with personal relationships (e.g. marriage, friendship) in the plague context. For example, when one member of a personal relationship is infected and the other is not, what is the specific nature of the responsibilities of each person in this situation? I argue that home care—which is the non-infected person's caring for her infected loved one in the home—is consistent with the responsibilities that are entailed by their relationship. Furthermore, I contend that, under certain circumstances, their engaging in home care would be respectful toward the interests of the community and, as such, might be sanctioned justifiably by public policy. Next, I seek to assess the moral responsibilities of health professionals in the plague context, giving special attention both to the likelihood that their care will be effective and to the risks that their providing care would bring upon themselves. I propose that health professionals have no standing obligation either to treat or to comfort infected persons. However, I argue that it would be morally good (i.e. supererogatory) of health professionals to enter a contractual obligation to provide such care. This conclusion has implications for the ways in which health officials and administrators should prepare for outbreaks; these I address as well. Finally, I evaluate various courses of action that are open to an infected person as he nears the end of his life. I contend that, whenever it appears that he can avoid infecting others, he does not have a duty to take his own life. However, in light of the threat that he poses to others, there are many reasons that it would be morally good for a dying, infected person to commit suicide.

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Chapter One: Home Care in Times of Plague

Almost exclusively, clinical bioethicists pose and answer questions in the context of day-to-day, medical practice in the West. This setting abounds with therapeutic procedures, drugs, and other resources to restore comfort and health to persons who suffer. In making moral judgments, we focus on patients, attend at times to their families, and—most rarely—consider the well-being of the rest of society as it is affected by particular treatment decisions.

Although this approach has resulted in a measure of moral progress with respect to our standard, clinical setting, it all but neglects the unique and compelling questions that arise in the context of an outbreak of a highly-virulent, infectious disease. In this setting—which I call the plague context—illness is acute, often violent and incurable, and persons who are infected necessarily pose a grave danger to those around them. In this paper, I examine a range of ethical questions in relationship to such an outbreak. Some of these questions are concerned with personal relationships (e.g. marriage, friendship) in the plague context. For example, when one member of a personal relationship is infected and the other is not, what is the specific nature of the responsibilities of each person in this situation? I argue that home care—which is the non-infected person's caring for her infected loved one in the home—is consistent with the responsibilities that are entailed by their relationship. Furthermore, I contend that, under certain circumstances, their engaging in home care would be respectful toward the interests of the community and, as such, might be sanctioned justifiably by public policy. Next, I seek to assess the moral responsibilities of health professionals in the plague context, giving special attention both to the likelihood that their care will be effective and to the risks that their providing care would bring upon themselves. I propose that health professionals have no standing obligation either to treat or to comfort infected persons. However, I argue that it would be morally good (i.e. supererogatory) of health professionals to enter a contractual obligation to provide such care. This conclusion has implications for the ways in which health officials and administrators should prepare for outbreaks; these I address as well. Finally, I evaluate various courses of action that are open to an infected person as he nears the end of his life. I contend that, whenever it appears that he can avoid infecting others, he does not have a duty to take his own life. However, in light of the threat that he poses to others, there are many reasons that it would be morally good for a dying, infected person to commit suicide. I begin with two, fictional narratives of plague contexts; these narratives illustrate several, important ways in which plague contexts can differ. Consequently, these fictional accounts will serve as ready references throughout this work.

An Outbreak of Viral Hemorrhagic Fever: Tanzania

It is early September. The maize harvest has begun in northern Tanzania. Workers take to the fields at sunrise, where they labor until returning to their huts for tea in mid-morning. One day, Priscus comes back especially fatigued, slightly dizzy, and complaining of a headache. His wife, Farheen, is anxious as she wipes his head and serves him tea. They are recently married. Because the harvest promises to be large this year, they are planning to start a family soon. After resting a while, Priscus returns to the fields, despite his wife's protests.

In late afternoon, when the day's work is finished, Priscus comes home weak and feverish. Now, both he and Farheen are concerned. Priscus is a strong man and rarely ill—an exceptional experience for persons in a region where both malaria and typhoid are endemic. However, the couple suspects that what is troubling Priscus is neither malaria nor typhoid. During the last month, they have heard of at least ten other cases of this strange fever in their village, the population of which is about four hundred. In addition to fever, each of the cases was accompanied by excessive bleeding. Only one of the sick sought treatment at the local hospital, which is the only medical facility in the district. That patient died in the hospital after the physicians and nurses could do little more than alleviate his bleeding. The other nine received care from family members in their homes. Two of these seem to have recovered. However, the other seven died within two weeks after their first signs of fever, and some of their family members have fallen ill in recent days.

Farheen and Priscus have been frightened by rumors that evil spirits have brought this awful fever upon their village, and, as evening falls, they kneel to pray that Priscus's fever will disappear. Though his fever wanes during the night, it resurges in the morning, and he remains in bed, battling episodes of nausea and delirium throughout the following day as Farheen brings him porridge and water. Using the same cloth each time, she wipes sweat from her husband's forehead, unaware of the risks that accompany contact with his body fluids. When Priscus is lucid, the two talk about their plans for the future; when he lapses into incoherence, Farheen waits and prays.

Although the hospital is only two miles from their hut, Farheen does not send for a taxi. Officials at the hospital, she suspects, might prevent her from staying with her husband during the course of his illness—a separation that would be unbearable for both of them. For now, remembering the vow that both she and Priscus made only months ago—a promise to preserve their love "in sickness and in health"—she offers to care for him at home. Priscus does not decline Farheen's offer; instead, he expresses his desire to stay at home with his wife. From their door, Farheen calls for a neighbor. When the elderly lady comes into their yard, Farheen explains the situation from the doorway, and the neighbor agrees to bring whatever supplies Farheen requests. Thanking her, Farheen closes the door and returns to her husband's side.

Below is a second, fictional narrative that depicts an example of the plague context.

A Flu Pandemic: An Urban Area in the United States

Three months ago, Turkish doctors confirmed the first cases of a new strain of avian flu that is person-to-person transmissible. Over the next month, the Turkish government implemented isolation measures for patients, quarantine plans for communities, international travel and trade restrictions, and widespread public heath education. Still, the virus steadily spread throughout much of the world. The first flu pandemic since 1968-69[1] had crossed the threshold, and, currently, the energies of most nations and international health groups are being consumed in the effort to combat it. Initially, a small percentage of the antiviral drugs that had been stockpiled by various countries proved effective for slowing transmission in certain areas. Now, however, despite an increase in drug production, this supply cannot be replenished rapidly enough. Consequently, most infected persons—especially those who cannot afford the medication—do not have access to antivirals. Furthermore, in many cases, these drugs

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[1] "Information about Influenza Pandemics" (October 17, 2005). Retrieved November 3, 2005, from http://www.cdc.gov/flu/avian/gen-info/pandemics.htm.

are doing little to alleviate the symptoms of infected persons. It is estimated that, thus far, more than half of those who have been infected have succumbed to the disease. A vaccine has not yet been developed, and, assuming that one is forthcoming, most labs predict that it will be at least three more months before distribution would begin.

In the last two months, tens of thousands of cases have been reported in the United States alone. With inpatient wards overflowing and lines for outpatient care lengthening, most urban hospitals and clinics in the U.S. cannot accommodate the number of persons who present for treatment. In an effort to slow the rate of transmission, health officials have distributed millions of masks and pairs of gloves. The media has readily cooperated with the health education plan initiated by the Department of Health and Human Services, and many people, suspecting that they are infected, are keeping themselves under voluntary quarantine to minimize their contact with others. Though grocery stores, banks, pharmacies, and other basic supply stores remain open, many other businesses have closed indefinitely. Public transportation has been scaled back significantly, and large public gatherings, though not yet prohibited, have been discouraged.

The current health situation in the urban area where Paul and Frank live is not different from that of most U.S. cities. Best friends since childhood and recent college graduates, these men are now co-workers. They share a small home near the business district of their city. One week ago, the manager of their company asked all of her employees to stay away from the office until they received further notice. For the first few days of their leave, due to travel limitations, both Paul and Frank decided to remain in the city, keep in touch with their family members across the country by telephone and e-mail, and follow international news. However, yesterday, Paul developed symptoms of the flu. Knowing that the local hospitals are crowded and that patients often must wait for hours before consulting a health professional, Frank expressed his willingness to stay home and care for Paul. Paul gratefully accepted his friend's offer. Fortunately, many of the city's pharmacies have antivirals in stock. Early today, wearing a mask and gloves, Frank visited a pharmacy and purchased the recommended dosage. He acquired more masks and gloves at one of the city's free distribution sites, and he purchased enough food to sustain himself and Paul for at least ten days. Returning home and finding that Paul still had a cough, aching muscles, and a fever, Frank called the city health department to report the suspected case. After putting on a clean mask and pair of gloves, Frank gave Paul the medicine and a cold compress.

Ethics in the Plague Context

Several ethical questions arise in the midst of what I call the "plague context," which is a quarantined or non-quarantined community in which there is an outbreak of a highly-virulent, infectious disease.[2] The fictional narratives above portray two kinds of

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[2] Plague is a bacterial infectious disease in animals and humans that is usually transmitted through the bite of a rodent flea. During plague epidemics of the middle ages and the modern period—including, most recently in the U.S., that of 1924-25 in Los Angeles—the disease was also transmitted from person to person through contact with infected tissues or fluids. These epidemics decimated populations in Europe, Asia, and Africa. Today, worldwide, an average of nearly 3,000 cases of plague are reported to the WHO annually. Though treatment is sometimes effective, the death rate remains over 50% for persons infected with pneumonic plague. "CDC Plague Home Page" (March 30, 2005). Retrieved January 22, 2006, from http://www.cdc.gov/ncidod/dvbid/plague/index.htm and accompanying pages.

As I explain below, a probable death for an infected person (i.e. a death rate greater than 50%) is a significant feature of the plague context. See the section titled "Factors Affecting P's Risk to the Community." Like the VHF outbreak and flu pandemic in the narratives, there are many diseases that have the potential to produce such a mortality rate; when such diseases do so, the phrase "plague context" would accurately describe the social situations they render. In choosing this phrase, I have in mind Laurie Garrett's *The Coming Plague: Newly Emerging Diseases in A World out of Balance* (New York: Penguin Books, 1994), in which she argues that the "history of our time will be marked by recurrent eruptions of newly discovered diseases…." and that "at least some of these diseases will generate large-scale, even worldwide epidemics." See page xv. I also have in mind Albert Camus's *The Plague*.

plague contexts, and they serve to introduce my focal point at the outset of this paper, which is the relative seclusion[3] of a non-infected person who is providing care for her infected loved one in a home context.[4] This home is set in the wider plague context. As the narratives show, I assume that there are both infected persons and non-infected persons in the plague context. However, aside from these general features, the two narratives have little in common. One way in which they differ, for example, is the extent or domain of the outbreak. In the story of Farheen and Priscus, the outbreak of viral hemorrhagic fever (VHF) is limited currently to their non-quarantined village. In contrast, in the situation of Frank and Paul, their city is one area that is affected by a global pandemic. The significance of the differences between these narratives will be explored in detail.[5] Before doing so, I offer an analysis of a further characteristic that these narratives share, which is the presence of a particular kind of relationship.

The relationships between Farheen and Priscus and between Frank and Paul are uniquely personal relationships. As in the narratives, it sometimes happens that, in the plague context, one member of a personal relationship is infected and the other is not. When this occurs, the relationship is disrupted, threatened by disease, and several questions emerge. For example, is it morally permissible for a non-infected person to offer to care for her infected loved one in the home context? If so, by what

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[3] I use the phrase "relative seclusion" because it admits of rare exceptions to complete seclusion. For example, the non-infected person might venture into the community on some errand that is necessary for her providing care.

[4] I use the phrase "home context" to denote any unsanitary, sheltered environment in which a health professional is not present at all times.

[5] An example of an important difference between these narratives is the prevalence of disease in each narrative. Prevalence refers to the percentage of the population that is infected at a given time. As I explain below, prevalence is one of many factors that influence the moral permissibility of home care. For my discussion of these factors and the ways in which they influence the permissibility of home care, see the section "Factors Affecting P's Risk to the Community," pages 20 through 25 below.

considerations might this permission be constrained? Should the infected person accept his loved one's offer to care for him? Because answers to these questions seem to depend upon the kind of responsibilities that are entailed by one's having a personal relationship, I first examine the nature of this relationship.

Personal Relationships within a Community

John Hardwig argues that at least two things characterize a personal relationship. First, my having a personal relationship with you means that I regard you and your well-being as one of my ends.[6] This involves my "seeing you and the realization of your goals as part of me and the realization of my goals."[7] Thus, to have a personal relationship is to regard another's well-being as part of one's own.[8] Furthermore, that I have a personal relationship with you, Hardwig contends, means that I want *you*.[9] It is not that I simply want an object, desire to give a gift, or to do an act, and you just happen to be a participant in this.[10] If this was the case, the object, gift, or act would be primary and you would be secondary. Instead, if I have a personal relationship with you, you are primary; it would not do to receive the object from, give the gift to, or do the act with another, for I want you. In this way, I consider you to be irreplaceable.[11] In addition to Hardwig's account, I propose that, if my relationship with you is personal, the essence of your commitment to me is the same as that of my commitment to you. That is, you regard me

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[6] John Hardwig, "In Search of an Ethics of Personal Relationships," *Is There a Duty to Die? and Other Essays in Bioethics* (New York: Routledge, 2000), 11.

[7] *Ibid*., 12.

[8] Here, I wish to remain uncommitted on the question of whether, in a personal relationship, another's well-being is a necessary or a sufficient condition of one's own well-being, or neither of the two. Hardwig espouses the third position. *Ibid*., 24.

[9] *Ibid*., 12.

[10] *Ibid*.

[11] *Ibid*., 11.

as irreplaceable and my well-being as part of your own. Finally, in a personal relationship, it might happen—and often does—that each person's devotion to the other grows or diminishes through time; nevertheless, the relationship is maintained, and each desires and intends to sustain her commitment to the other.

I assume that the features of a personal relationship elucidated above capture much of the essence of our relationships with best friends and loved ones. It is a personal relationship, in this sense, that Farheen shares with Priscus and that Frank shares with Paul. Throughout this paper, I use "FN" to indicate the non-infected member of the personal relationship and "P" to indicate the infected member of this relationship. "FN" abbreviates "P's family member or friend who is not infected." In the narratives, both Farheen and Frank are FNs.[12] "P" abbreviates "infected person who is a loved one of FN." In the narratives, both Priscus and Paul are Ps.

While FN has a personal relationship with P in that P's well-being is part of FN's own, everyone else in the community has *at least an interest* in P's well-being insofar as the outcome of P's treatment[13] might affect his or her own well-being. This is the case even when such persons have no personal relationship with P. The interest of non-infected persons in P's well-being is profound, for the kind and quality of care that P receives affects the likelihood that he will infect others, and infection is life-threatening.[14]

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[12] Below, in my analysis of FN's responsibilities, I allow for the possibility that FN *is* infected—or *might be* infected—but, because she is asymptomatic, she *believes* that she is not infected. I assume that FN, in not having had herself tested for infection, has not been negligent. Of course, if FN believed herself to be infected, her responsibilities toward her loved ones and the community would change drastically.

[13] I use the terms "treatment" and "care" loosely in reference to the well-intentions that P receives during the course of P's illness.

[14] Regarding this interest, it is true that, while a particular non-infect person might never come into contact with P, this person might be infected indirectly by P in that someone whom P infects (e.g. FN) could in turn infect him or her. Furthermore, the strength of the interest that a non-infected person has in P's care

The interest that infected persons have in P’s well-being is less intense than is that of non-infected persons, for, although it is usually the case that infected persons cannot be re-infected by P, P could infect the loved ones of infected persons. If these loved ones were to be infected, the well-being of the infected persons to whom they are close would be damaged also. Therefore, everyone in the plague context has at least some interest in P’s well-being.[15] In the section below, I argue that these interests, in addition to those of FN and P, should be considered when decisions regarding P’s treatment are made.

Caring for P and Considering the Interests of the Community

During non-plague times in the United States,[16] medical treatment decisions focus almost exclusively upon the patient and that which she and her caregivers regard as being in her best interest. Until the last few decades of the twentieth century, most Western physicians made such treatment decisions in a paternalistic fashion.[17] More recently, ethicists have argued that paternalism shows disregard for the self-determining capacity of patients, who often understand what is in their best interest better than anyone else does. As a result, patients have been given more power to make decisions concerning their treatment. Nevertheless, whether it is primarily the patient or a health professional

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depends upon the risk that P poses to him or her. As I discuss below, the severity of this risk depends in part upon the ways in which P is treated.

[15] This claim does not depend upon *any* persons’ being *conscious* of their interest in P’s well-being. Presumably, everyone has an interest in continuing to live. To some extent, these interests are jeopardized by how P is treated. For example, that P receives medication might mean that another infected person does not. Therefore, everyone has an interest in P’s well-being, whether or not they are aware of P’s case.

[16] The most recent plague epidemic in the U.S. occurred in Los Angeles in 1924-25. See note 2. Cholera outbreaks were also common in the U.S. in the 1800s. The global flu pandemic of 1918-19 resulted in more than half a million deaths in the U.S. However, I am not aware whether these—or any other—outbreaks in the U.S. were “plague contexts” in that, for one who was infected, death was probable. Regarding a probable death for an infected person as a feature of the plague context, see the section titled “Factors Affecting P’s Risk to the Community.”

[17] Edmund D. Pellegrino and David C. Thomasma, *A Philosophical Basis of Medical Practice: Toward a Philosophy and Ethic of the Healing Professions* (New York: Oxford University Press, 1981), 203.

who renders the judgment, decisions regarding treatment continue to be almost exclusively patient-centered during non-plague times.[18]

Hardwig argues that this patient-centered approach to medical care is a flawed result of an "individualistic fantasy" that "leads us to imagine that lives are separate and unconnected."[19] This is a fantasy, he says, because it is out of touch with the reality that most of our lives are closely connected with those of others; because of this connection, our decisions inevitably affect others.[20] One cannot join a team, visit a restaurant, go to work, or do almost anything without having one's decision and course of action influence other people. This is most obvious within one's personal relationships.[21] In light of this, Hardwig contends that it is irresponsible to act as if one's behavior does not affect others.[22] Instead, one should take account of all who have a vested interest in one's decision, seeking the course of action that will be best for all concerned.[23] In caring for

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[18] John Hardwig, *Is There a Duty to Die? and Other Essays in Bioethics* (New York: Routledge, 2000), 4-5.

[19] John Hardwig, "Is There a Duty to Die?" *Is There a Duty to Die? and Other Essays in Bioethics* (New York: Routledge, 2000), 121. The "individualistic fantasy," Hardwig contends, is rooted in a misguided notion of autonomy, which asserts that medical decisions should be made in such a way as to give privileged consideration to the interests of patients. On this understanding of autonomy, we might respect patients' interests while either excluding or considering—but only to a limited degree—those of others. On this view, if others' interests are considered at all, they must never override those of the patient. This egoistic idea of autonomy is flawed, Hardwig holds, because it ignores the fact that others can have a greater stake in whatever medical decision is made than does the patient. Consequently, Hardwig proposes that an appropriate understanding of autonomy entails that patients are responsible for—and, as such, must choose with consideration for—the interests of others. This notion of autonomy undergirds Hardwig's "family-centered" approach to medical decisions, which is discussed below. See Hardwig, "What About the Family?" *Is There a Duty to Die? and Other Essays in Bioethics* (New York: Routledge, 2000), 29-30, 38-39.

[20] Hardwig, "What About the Family?" 31.

[21] *Ibid*., 32-33.

[22] *Ibid*., 31.

[23] *Ibid*., 31-32. Hardwig explains that, in speaking of that which is "best for all concerned," he does not wish to commit himself to a brand of utilitarianism. He affirms that, contrary to a utilitarian approach, there might be times in which family members, for example, should make great sacrifices in the interest of their loved one who is sick, even if such sacrifices will not be "outweighed" by the pleasure that is produced.

the sick, this means that our patient-centered ethics should be replaced with one that is "family-centered."[24]

For Hardwig, anyone who has a personal relationship with the infirm is part of the patient's "family" and, as such, has interests that should be considered in decisions regarding the patient's treatment.[25] Such decisions might be extremely burdensome, Hardwig admits, especially when the moral path is not perfectly aligned with the wishes of a patient who is stubborn, seriously ill and suffering, or even on the verge of death.[26] For example, consider a man who, despite his family's poverty and his lack of insurance, continues to insist upon receiving expensive chemotherapy for cancer that is in a terminal stage. Or consider the case of a widow who, acknowledging that her Alzheimer's is worsening, does not want to be a "burden" to her daughter who is both willing and able to care for her. What should be done in these circumstances? In some situations, it might be permissible to let the patient's interests override those of others who have an interest in the decision. However, at other times, considering only the patient's interests might overburden the rest of the family emotionally, professionally, socially, and financially in a way that is unfair.[27] Hardwig concludes that, however difficult such decisions might be, we must recognize that "patients too have moral obligations, obligations to try to protect the lives of their families from destruction resulting from their illnesses."[28] These obligations can come into conflict with a patient-centered approach to medical treatment

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[24] Hardwig, 6.
[25] *Ibid*., 8, footnote 2.
[26] Hardwig, "Duty to Die?" 125-27.
[27] *Ibid*., 122-24.
[28] Hardwig, "Family?" 32.

and with the notion of autonomy on which that approach rests.[29] In contrast, these obligations suggest the appropriateness of a family-centered perspective.

Above, I considered two divergent approaches to medical care during non-plague times. In light of that discussion, I transition now to healthcare in the plague context and propose that there are two approaches to treatment decisions—and public health decisions more broadly—that ought to be avoided because they are likely to cause harm. These are 1) a patient-focused approach, which fails to take seriously the danger that the patient poses to the community, and 2) a community-focused approach, which, for the sake of protecting the well-being of the community, shows too little consideration for the patient's interests.[30] In contrast, although Hardwig restricts his focus to the patient and to his or her loved ones, his view seems relevant to the plague context that I have described. This is because, in the plague context, the community's interests in a patient's well-being are analogous to the interests that family members have in a loved one's well-being in non-plague settings. In the plague context, the sphere of persons who have an interest in the patient's well-being extends far beyond those who have a personal relationship with the patient. As we have seen, this sphere encompasses everyone who is present with P in the plague context. Hardwig's view is relevant here because the interests of these

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[29] See note 19 above.

[30] Of course, it is not surprising that the community-focused approach to medical decisions is not common in non-plague times, for it is rare during such times that a patient's being ill has serious repercussions for the health of many others in the community. An exception might be an HIV/AIDS patient whose reckless behavior endangers others, for some would argue that, in such a case, the community's interests should take precedence over those of the patient. Below, I argue that the community-focused approach, when implemented in the plague context, might drive a false wedge between the interests of the community on one side and those of the patient and her loved ones on the other.

persons in P’s treatment can be very intense.[31] For both infected and non-infected persons, social and emotional well-being are threatened by P’s being ill and contagious. Furthermore, for those who are not infected, the extent to which their health and lives are jeopardized is influenced by the way in which P receives care.[32] Therefore, while it is obvious that both FN and P have interests in P’s treatment that are worthy of consideration, the interests of everyone else in the plague context should also be taken into account when decisions regarding P’s care are made. To do otherwise—that is, to consider the interests of either group to the exclusion of those of the other—is potentially damaging to the members of the marginalized group.

The discussion above raises a question regarding the extent to which the interests of persons in the community should be considered. I suggest that the extent to which these interests should be considered is directly proportional to the “strength” of those interests. The strength of the interests that others have in P’s care is relative to the level of risk that P poses to them. As this risk increases or decreases, the strength of the community’s interests increases or decreases, respectively. Furthermore, an assessment of the risk that P poses to others is dependent upon many factors that can vary from one plague context to another. Below, I consider these factors and their influence upon the strength of the interests that others have in P’s care. Before doing so, I address the relationship between FN and P as if it was separated in ethical space, so to speak, from all

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[31] However, the primary reason why Hardwig’s view is relevant here is that, as I argue below, the interests that others have in P’s treatment cannot be distinguished from the interests that these persons have in maintaining their personal relationships. Briefly, many who are not infected are interested in P’s treatment because they do not want to be infected by P—or by someone whom P infects—and risk losing their personal relationships. Similarly, many infected persons are interested in P’s treatment because they do not want P to infect those with whom they have personal relationships.

[32] This might be true of infected persons as well when the quality of care that P receives detracts from that which is given to others who are infected.

other moral considerations. I argue that, given the nature of their relationship, FN should offer to care for P in the home context, and P is permitted either to accept or to decline FN's offer.

The Asymmetry of Moral Responsibility within the Care Relationship

Thus far, I have sought 1) to characterize the personal relationship that exists between FN and P, and 2) to describe the interests that others have in P's treatment, arguing that these interests should be considered when decisions regarding P's care are made. Now, setting all other moral considerations aside for the moment and attending only to the nature of the relationship between FN and P, I seek to identify the moral responsibilities that accompany this relationship. I contend that moral responsibility within the care relationship is asymmetrical. That is, under specific conditions, FN should offer to care for P, while P, who should not ask FN to provide care, is permitted either to receive or to refuse that care.

Before arguing for this moral asymmetry, it is necessary that I narrow the focus of the argument once more. Presumably, it is possible to distinguish at least two stages in the progression of P's disease. These are what I call the battling stage and the dying stage. In the battling stage, P is fighting to survive and, from a clinical perspective, his overcoming the disease is still possible. In the dying stage, from a clinical perspective, it is evident that P has lost the battle and that P's death is immanent.[33]

Below, I focus on the battling stage of P's disease because it is in this stage that the moral asymmetry to which I want to call attention is most clearly present. The reason

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[33] Admittedly, sometimes these two stages cannot be neatly distinguished, and the boundary—however blurred—between the two will be specific to both the disease and the patient. Consequently, the time at which certain decisions should be made with regard to care will depend uniquely upon both the disease and the patient.

that moral asymmetry is present during the battling stage is due to the fact that, at this time, the personal relationship between FN and P remains fully intact; that is, their relationship retains the essential features that were described above. In the battling stage, there remains a possibility that P will recover; consequently, if FN and P are aware of this,[34] then, from their perspectives, their relationship might be maintained indefinitely. In contrast, that P is in the dying stage entails an immanent end to this relationship, and the hope of maintaining their relationship indefinitely is lost. The hope of maintaining a relationship is a significant component of any personal relationship, for, when this hope is lost, the extent to which each person can regard the other's ends as part of her own is diminished.[35] For example, if Priscus is in the dying stage, he and Farheen can no longer share the goal of raising a family together. Thus, Priscus's being in the dying stage entails that his relationship with Farheen has been diminished. To some extent then, each has been divested of responsibility for the other's ends.[36] In contrast, in the battling

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[34] I have assumed that FN and P are not health professionals. Nevertheless, as I explain below, FN and P might be able to distinguish the battling and dying stages of P's illness with the assistance of a health inspection team.

[35] Even if I have good reasons to believe that you will die tomorrow—as I might, if you are in the dying stage—it is undoubtedly still the case that I want you. At least in this respect, our personal relationship remains intact. However, because you will die tomorrow, the extent to which I can make the realization of your goals a part of my own—and, especially, vice versa—has been vastly diminished. In this way, we have been divested of a significant feature of our personal relationship.

Admittedly, there are persons who do not regard a loved one's death as a permanent end to their relationship with that loved one. For example, such persons might believe that they will be reunited with their deceased loved one when they join that loved one in an afterlife. In light of such beliefs, my analysis of the relationship between FN and P is restricted to their interacting while both persons are on this side of death.

[36] Whether it follows from this that FN's caring for P in the dying stage is any less permissible than I will contend it is during the battling stage is a question that I take up later. At that point, I will argue that the permissibility of FN's caring for P at home—during *any* stage of P's illness—is a function of the risk that P would pose to others during home care. Here, I am only seeking to identify the nature and responsibilities of this relationship as though it was isolated from other considerations. As I explain above, while this relationship remains clearly intact in the battling stage, this relationship is diminished in the dying stage. Consequently, because the analysis of the moral responsibilities of FN and P offered in this section depends upon the nature of their personal relationship, that analysis cannot apply to the dying stage of P's illness.

stage, each can maintain the other’s ends as his own in good conscience, believing that he will have the opportunity to fulfill the relevant responsibilities. Therefore, during the battling stage, the hope that both FN and P have in their future relationship is a morally relevant difference between this stage and the dying stage. Below, given the nature of their personal relationship, I seek both to identify the responsibilities that accompany this relationship and to assess the ways in which these responsibilities should influence decisions regarding P’s treatment during the battling stage.

The Moral Responsibility of P

Once P’s symptoms are recognized, if P is to be cared for, who should provide such care, and where should it be given? For example, P might attempt to care for himself within his home, he might ask a loved one to care for him there, or P might entrust himself to the care of health professionals in a medical facility. In this section, I argue that there is one action that P should not take with respect to seeking care. In the following section, I speak to that which FN should do for her infected loved one.

Due to the highly-infectious nature of P’s disease, P should not *request* to be cared for by any non-infected person with whom P has a personal relationship. This request should not be made in *any* setting. One might object that, if FN is both competent and well-informed about P’s illness, there is no harm in P’s asking for her care; thus, P is permitted to request that FN care for him. However, having forged a close bond with another person—a relationship in which one regards the other’s well-being as part of one’s own—one has taken a measure of responsibility for the other’s well-being. That is, protecting the other’s physical and psychological health is a purpose that one adopts when one enters such a relationship. Because P’s disease is so very contagious, the health of any person who provides care for P might be in serious jeopardy. Providing care around the clock is also taxing psychologically, and witnessing the decline of a loved one can be deeply disturbing. Even if P knows that FN is aware of all of this, he should not risk endangering FN by asking her to care for him. If FN has a responsibility to care for P, it is inappropriate for P to initiate that responsibility for FN or to prompt her to recognize it. Instead, if he knows that FN is competent and informed, P should trust her to respond on her own initiative; to do otherwise would be to disrupt the “balance” of responsibility within the relationship. Therefore, P’s requesting FN’s care would be subject to moral criticism because it would involve a lack of consideration for the threat that P poses to FN’s well-being and, in that, a disregard for the responsibility that P undertook in entering the relationship. Although it is likely that P would prefer that FN provide care for him, given the nature of their relationship, P should not request care from FN.[37]

The Moral Responsibility of FN

Although P should not request that FN provide care, FN should *offer* to care for P.[38] Having developed a personal relationship with P—adopting P’s well-being as part of her own—FN committed herself to doing what she can to protect and to preserve P’s health. Not only is health an essential feature of P’s well-being, but, presumably, it is also a necessary condition for pursuing most of the ends that P has chosen for himself.

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[37] We might try to imagine the emotional conflict that P is likely to experience as he wants a loved one near by, hopes for her attendance, and yet does not want to endanger her by requesting that she provide care. Furthermore, I do not intend to ignore the fact that, in the context of some personal relationships, P would be justified in expecting FN to offer to care for him. For example, on the basis of their wedding vow, Priscus might expect Farheen to offer to care for him. However, as I have argued, it is his having made the same vow that should dissuade Priscus from requesting her care.

[38] Below, I argue that there are non-sanitary conditions under which FN should be permitted to care for P.

Because FN shares those ends, she should seek to preserve the conditions upon which their achievement is dependent. For this reason, FN should offer to care for P. FN's refraining from offering to care for P would reflect her unwillingness to undertake a responsibility that is entailed by their relationship. Of course, in caring for P, FN puts her own health at risk. However, to some extent, her doing so is inevitable if she is to fulfill the responsibilities that accompany her relationship with P. Paradoxically, then, while P should not ask FN to put her well-being at risk, FN should risk doing so by offering to care for P. In this way, FN initiates her own responsibility and maintains the balance of commitment within the relationship.

The Moral Permission of P

Once FN has offered to care for P, the "weight" of responsibility within their relationship is on the side of P. P is permitted either to decline or to assent to her offer, for each is consistent with his responsibility for FN.[39] In consideration of the risk to FN that is involved in her providing care, P is permitted to decline such treatment out of respect for FN's well-being. One might object that, in declining FN's offer, P might be weakening his relationship with FN, for the extent to which FN could share P's ends—at least during the course of P's illness—is likely to be severely limited. For example, if Paul had declined Frank's offer to care, Frank would then have been limited in his ability both to help Paul recover and to continue working toward a promotion. Thus, it must be granted that P's declining FN's offer might weaken their relationship for a time.

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[39] Whenever I speak of P's responsibility within the context of his relationship with FN, I intend "P is permitted…." in the sense that "P is ethically justified…." This kind of permissibility can be distinguished from social/political permission that is granted through law or policy. Below, I address the latter kind of permission as it relates to whether the care relationship between FN and P should be sanctioned in the plague context.

However, P is not at fault for restricting his relationship with FN in this way. In declining FN's offer, P does not disregard any responsibilities that he undertook when he developed this relationship with FN. Instead, P simply limits the relationship in an effort to protect FN's well-being, and his doing so is a way of preserving FN's chosen ends. Thus, P's declining FN's offer is morally permissible, perhaps even praiseworthy.[40]

On the other hand, P is permitted to receive care from FN. In offering to provide care, FN reinforces her commitment to P's well-being; specifically, she identifies the restoration of P's health as one of her ends. In this way, P knows that FN continues to share his ends. Thus, by assenting to FN's offer to provide care, P is able to continue sharing FN's ends—at least one of those ends, namely her caring for P. Therefore, P is permitted to assent to FN's offer, for doing so would maintain—and, especially if P recovers, probably strengthen—their relationship.

The objection might be raised that, in accepting FN's offer to care for him, P would be disregarding one of his own goals, namely that of protecting FN's well-being—which, presumably, is also one of FN's goals. Thus, the objection concludes, P would be wrong to accept FN's offer. However, to reply, the analysis of moral responsibilities that is offered in this section applies only to the relationship as if it was isolated from "external" conditions, which are the factors that affect P's risk to the community. As I

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[40] Whether FN should respect P's wish to decline her offer depends on P's reasons for doing so. In most circumstances, we might say that, if P is permitted to decline FN's offer, FN should respect his so declining. However, if Paul, for example, had refused Frank's offer to care for him, Frank appears to have good reasons to override Paul's wishes and care for him anyway. First, since the hospitals are crowded, Paul has minimal access to professional care. Furthermore, Paul is still in the battling stage; if he is cared for properly, he has a good chance to recover. Given these considerations, it is not obvious that Frank's overriding Paul's wishes would be inappropriate. These points become even more pressing if Paul, by himself, could not provide some essential aspect of his own care, such as his meals.

explain below, with respect to these factors, it is correct that the plague context might be such that FN should not offer to care for P; if FN was to offer impermissibly, P should refuse that offer. On the other hand, the factors that affect P's risk to others in the plague context might be such that the risk that P poses both to FN and the community is relatively low. Consequently, in these circumstances, P's accepting FN's offer to care for him would not involve negligence toward FN's well-being. Therefore, P's accepting FN's offer would be permissible in such circumstances.[41]

To summarize, when P is in the battling stage, the essence of his personal relationship with FN remains intact. In light of his responsibilities that accompany this relationship, P should not ask FN to care for him. However, at the same time, FN's responsibilities indicate that she should offer to care for P. Finally, P, in either accepting or declining her offer, would not be negligent toward FN's ends and well-being; instead, both options respect FN and, thus, are morally permissible.

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[41] If I am correct in arguing that P is permitted to assent to FN's offer, one might wonder whether it also would be permissible for P to assent to the offer of an informed and competent stranger—or an acquaintance—to care for him. Although we assume that neither P nor the stranger had any prior, explicit commitment to the well-being of the other, we can imagine a stranger's making such an offer. I can see nothing objectionable about P's assenting to the stranger's offer when the factors affecting P's risk to the community are such that home care is permissible because it would contain risk at least as well as would the best care alternative. In this situation, from the standpoint of the interests of the community, it does not matter who administers home care, just as long as someone does so to protect the community's interests. In contrast, P's assenting to the stranger's offer would not be permissible when it is not clear whether home care would contain risk at least as well as would some other care alternative. In this situation, the stranger's caring for P would not respect the interests that community members have in not being infected. However, below, I contend that *FN's* caring for P *in these same circumstances* would entail a good—that of maintaining a personal relationship—that the stranger's caring for P would not. Because most others in the plague context could affirm this good, there are circumstances in which FN's caring for P would be permissible while the stranger's caring for P would not be. In these latter circumstances, the personal relationship between FN and P makes a significant difference in moral judgments regarding the care relationship.

An Objection: The Community's Interests Always Override those of FN and P

Having set aside all other moral considerations and attended only to the relationship between FN and P and their accompanying responsibilities, I now want to introduce an objection to the moral permissibility of the care relationship for which I have argued. This objection stems from a community-focused approach to public health decisions. One might contend that, in consideration of the interests that others in the plague context have in P's treatment, FN should not offer to care for P, nor should P be permitted to receive such care, for FN's caring for P would place the community at risk unnecessarily. If FN is infected while she cares for P, it is probable that others in turn will be infected by her. In contrast, the likelihood that P will infect anyone else is greatly diminished if P is either in isolation or in the care of health professionals in a sanitary environment. Together, the interests that non-infected persons have in avoiding infection, and the interests that their infected loved ones have in not losing them to the disease, override the interests that P and FN have in maintaining their personal relationship. Therefore, the objection concludes, FN should not care for P, and P should be cared for in some other way—presumably, in a medical facility—that both respects and protects the interests of the community.

Despite the force of this argument, it is not necessarily the case that the interests of others override those of P and FN. As noted above, the strength of the community's interests in P's treatment is relative to the level of risk that P poses to his community, and that level of risk is a function of various factors that can fluctuate from one plague context to another. In the section below, I identify many of these risk factors and show how a change in them affects P's threat to the community. I propose that moral judgments regarding FN's caring for P can be understood along a spectrum. Generally, as the risk to the community of FN's caring for P in the home context decreases, the moral permissibility of FN's caring for P increases, and vice versa. Consequently, there are, I maintain, circumstances in which FN's caring for P in the home context is morally permissible and others in which such care is impermissible.

Factors Affecting P's Risk to the Community

If FN is caring for P in the home context, there are numerous factors that would influence the degree of danger that P presents to others—including FN—in the plague context. The most fundamental of these factors—insofar as the force of the other factors is relative to it—is the severity of the particular disease that has produced the outbreak. The severity of a disease, as it relates to the physical well-being of those in the plague context, is determined by its transmissibility, the symptoms it produces, its course, and its rates of morbidity and mortality.

In this sense, the VHF described in the narrative of Farheen and Priscus is more severe than the flu that is pandemic in the narrative of Frank and Paul. However, it is significant that, for each of these diseases, it is *probable* that a person who is infected will die from the disease. This probability is not easily mitigated; death might not cease to be probable even for patients who receive optimal professional care, including the best available pharmaceuticals. Death's being probable means that FN's relinquishing P either to isolation or to the care of health professionals is likely to be an act of final separation for FN and P.[42] Thus, we can understand the urgency of both FN and P to maintain their

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[42] Death's being probable for any person who is infected is an essential feature of the plague context that I have described. See note 2 above.

relationship during the battling stage of P's illness. In the following section, I argue that there are conditions in which the desire of FN and P to maintain their personal relationship during the battling stage of P's illness ought to be respected. In this section, I seek to describe those conditions through an analysis of the factors that affect the risk that P poses to the community.

There are at least eight factors that affect the level of risk that P poses to the community as he is cared for by FN in the home context. Just as the severity of the disease can fluctuate from one plague context to another, so can the status of each of these factors.[43] As I have argued, P is a danger to the community insofar as he might infect others; all persons in the plague context have interests in averting the risks that P poses to their well-being; thus, responsible decisions regarding the way in which P receives care will consider the interests of the community. Generally, therefore, as the risk to the community of FN's caring for P decreases, the moral permissibility of FN's caring for P in the home context[44] increases, and vice versa. As each of the following six factors increases, risk decreases, so moral permission increases.

A. Prevalence of infection (i.e. the percentage of the population infected at a given time). In general, as prevalence increases, the risk that any infected person presents to others decreases; this is because the individual's risk is

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[43] It is also the case that the status of the following factors can change over time within a single plague context. Therefore, any description of the status of these factors, their influence on the risk that P poses to the community, and the moral permissibility of FN's caring for P must be qualified in relationship to a particular time. This will be illustrated as I return to the narratives—in both of which the conditions of "today" have been described—and offer an evaluation of the moral permissibility of FN's caring for P at that time in each story.

[44] For short, I refer to this permissibility as "moral permission."

dissipated by the risk posed by other infected persons. Thus, moral permission increases as A increases.

B. The extent to which both FN and P affirm a clinical perspective of P’s disease, including etiology, means of transmission, optimal methods of care, and typical course of the illness. As this perspective increases, the risk that P poses to others is likely to decrease because both FN and P become more likely to take precautions to limit the possibility that P will transmit the disease to others. So, moral permission tends to increase as B increases.

C. The extent to which FN and P utilize non-pharmaceutical resources (e.g. gloves, masks, educational materials regarding disease). Because such resources reduce the risk of transmission from P to FN, moral permission increases as C increases.

D. The extent to which non-infected persons in the plague context have received—or the likelihood of their coming to receive—a vaccine. In particular, whether or not FN—who is the primary means of P’s infecting others in the plague context—has received a vaccine influences this factor more than any other consideration. Because a vaccine reduces one’s chance of being infected, moral permission increases as D increases.

E. The extent to which P uses pharmaceutical resources (e.g. antiviral drugs) to reduce the risk of his transmitting the disease to FN. Because P’s using such resources would mitigate his threat to others, moral permission increases as E increases.

F. The extent to which FN and P remain in the home context and, in the home, have access to basic necessities (e.g. food, water, waste disposal, laundry, communication with health professionals) that would limit the necessity of their coming into contact with others.[45] Since diseases are often transmitted through contact with others, the risk that P poses to others—either directly or through FN—decreases as their contact with others decreases. Therefore, moral permission increases as F increases.

As each of the two remaining factors decreases, risk decreases, so moral permission increases.

G. The extent to which P has access to professional care, and the quality of that care relative to the quality of home care. P's having access to care involves both his ability to reach a medical facility and the ability of that facility to accommodate him. Whether P's threat to others is less severe when P is in a medical facility than it is when he is in the home context with FN depends upon the relative quality of care that P receives in the medical facility. Therefore, moral permission increases as G decreases; that is, as P has less access to professional care, and as the quality of that care decreases, FN's caring for P in the home is increasingly an appropriate means of containing P's risk to others.

H. The extent to which infected persons have received, are receiving, or are likely to receive pharmaceutical resources that increase their chance of survival and/or reduce the chance of their infecting others. If other infected

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[45] Such contact includes visits that others make to the home context.

persons in the plague context receive pharmaceuticals that decrease their threat to others, the risk that P poses to others increases. However, the fewer the infected persons who use pharmaceuticals, the less the threat that P poses to others.[46] So, moral permission increases as H decreases.

In consideration of the eight factors above, it does not seem that a difference in any one of them—when taken alone, and all other things being equal—could necessarily distinguish a case of moral permission from another in which FN's caring for P would be impermissible. If this is correct, it is likely that we cannot finely demarcate cases of moral permission from those in which home care would be impermissible. Instead, moral judgments regarding FN's caring for P can be understood along a spectrum, and the permissibility of her doing so becomes more or less evident as the accompanying risk to others—and to herself—decreases or increases, respectively.

Returning to the narratives, we can conclude that there are good reasons to suppose that Frank's caring for Paul is morally permissible while Farheen's caring for Priscus is not. In the story of the avian flu pandemic, prevalence is high and Paul's access to professional care is poor. Furthermore, Paul is taking antivirals while most other infected persons are not; Frank is wearing gloves and a mask to protect himself from infection; and it is likely that both men can stay confined to their home for the course of Paul's illness. Each of these factors increases moral permission. However, Frank has not received a vaccine, and he is not likely to be vaccinated in the near future as he cares for Paul. Although this last factor mitigates the moral permissibility of

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[46] This is similar to A above. As fewer infected persons use pharmaceuticals, the contagiousness of these infected persons increases, which, in turn, dissipates the risk that any infected person poses to others.

Frank’s caring for Paul, overall, there are good reasons to conclude that his doing so is permissible.

In contrast, in the story of the VHF outbreak in Tanzania, prevalence is low and Priscus has access to professional care. Though it is improbable that *any* care will result in Priscus’s recovery, we assume that workers in the local hospital can more adequately protect themselves—and the rest of the community—from infection than can Farheen. She is not using either gloves or a mask as she cares for her husband, and she does not understand the significance of doing so. Furthermore, Priscus is not taking any medication that would reduce his chances of transmitting the virus to his wife; Farheen has not received a vaccine and, since none exist, she is not likely to receive one; and the couple is likely to have contact with others during the course of Priscus’s illness.[47] Each of these factors detracts from the moral permissibility of Farheen’s caring for Priscus in the home context. Only one factor would increase moral permission, and that is the likelihood that other infected persons are not taking medication to reduce their chances of transmitting the virus. Therefore, there are good reasons to suppose that Farheen’s caring for Priscus is not morally permissible.

Respect for the Meaning of Personal Relationships

In the analysis above, I draw the probabilistic conclusion that there are circumstances in the plague context in which FN’s caring for P in the home context is morally permissible. An illustration of such circumstances is offered in the narrative of Frank’s caring for Paul in the midst of an avian flu pandemic. This thesis is maintained

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[47] Not only is the couple likely to have contact with their elderly neighbor as she supplies them with necessities, but, since they seem to have no understanding of how the virus is transmitted, they might be inclined to permit others (e.g. relatives, clergy, curious villagers) to enter their home as well. Farheen might also venture away from the home and come into contact with others.

against the objection that, in consideration of the interests of the community, FN’s caring for P is not permissible *under any circumstances*. Because I agree with the objection insofar as decisions regarding the way in which P receives treatment should consider the interests of others in the plague context, I have sought to describe conditions in which a non-infected person’s caring for an infected loved one would adequately accommodate the interests that members of the community have in the infected person’s treatment. That is, a non-infected person’s caring for an infected loved one is morally permissible when it sufficiently mitigates the risk that home care poses to others.

Admittedly, phrases like “adequately accommodates interests” and “sufficiently mitigates risk” are vague at best. Unless their meaning is further informed, we might be tempted to conclude that a categorical prohibition of home care is the only appropriate policy. That is, if cases of moral permission cannot be distinguished readily from those in which home care is impermissible, it might be more prudent to prohibit home care categorically than to permit such care and thereby risk infections that might have been prevented.

In reply, although it is unlikely that a definitive description of cases of moral permission could be offered, a case of moral permission is likely to have one of two general features. First, even if P has access to professional medical care, and when other factors weigh in favor of moral permission, FN’s caring for P at home is permissible if the risk that P poses to others in the home context *is comparable to* the risk that P would pose to others if he was in the medical facility to which he has access. This is one reason why, as their circumstances have been described thus far, Farheen’s caring for Priscus is not morally permissible. The local hospital and its staff are capable of containing risk much more effectively than are Farheen and Priscus in their home context. Second, when, as in the case of Frank and Paul, there is either no access to professional care or such access is very limited, home care is likely to be one of the most effective means of mitigating risk. Thus, in such circumstances, whether or not other factors weigh in favor of moral permission, home care is morally permissible. Therefore, generally, we have identified at least two cases of moral permission: 1) FN’s caring for P in the home context is morally permissible when its accompanying risk is comparable to that of accessible, professional care, and 2) home care is permissible when FN and P have limited or no access to professional care and no means of containing risk that is superior to home care. In each of these cases, that home care is morally permissible turns on the consideration that it would contain risk *at least as well* as would the best alternative.

Certainly, despite these two situations in which home care is likely to be morally permissible, there are various possible circumstances in which our judgments regarding the ethical status of home care would be inconclusive with regard to P’s risk to the community. For example, would care be permissible if, all other factors remaining the same as in the narrative, Farheen consistently wears both a mask and gloves and neither she nor Priscus interacts with others? What if, all other factors remaining the same, Paul does not take antivirals? When confronted with situations in which our moral judgments are inconclusive with regard to risk,[48] I contend that there is a good reason to adjudicate in favor of the moral permissibility of home care. This reason has to do with the meaning and value that personal relationships have for most people in the community.

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[48] That is, our moral judgments are inconclusive because, after a comparative analysis of the quality of home care versus that of professional care, it is not clear whether home care would contain risk at least as well as would professional care—which, presumably, is the best alternative.

Despite the accompanying risks to the community, FN's caring for P is morally permissible even when the factors that affect risk do not weigh clearly either for or against moral permission. As noted above, because there is such a high mortality rate in the plague context, FN's relinquishing P to health professionals is likely to be an act of final separation. Because of this, I suspect that a non-infected person's parting with an infected loved one is often unbearable for both persons. Not surprisingly, non-infected persons frequently refuse the advice of officials to place infected loved ones in the care of health professionals.[49] The reason for this, I propose, is that life's having meaning for FN and P often depends to a great extent upon their maintaining their personal relationship. If FN and P are required to part as FN entrusts P to health professionals, it is likely that much of the meaning of their relationship will be lost.

Even when, in consideration of P's risk to the community, our judgment regarding home care is inconclusive, home care is morally permissible because respect for the meaning of the relationship between FN and P *is compatible with* respect for the interests of the community. This is the case because the interests that others in the plague context have in P's treatment cannot be separated from the value that many of the same persons place on personal relationships. The desire of FN and P to maintain their relationship is compatible with the interests of the community at two levels. The first level is abstract and has to do with the value of personal relationships that FN and P hold in common with most members of the community. Many non-infected persons are interested in P's treatment because they do not want to be infected and, as a result, risk losing *their*

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[49] For an example, see "Angola Officials Try to Contain Signs of Marburg Panic" (April 12, 2005). Retrieved May 3, 2005, from http://www.medpagetoday.com/tbindex.cfm?tbid=873&topicid=79.

personal relationships. Similarly, one reason that many infected persons are interested in P's treatment has to do with their not wanting P to infect *their* loved ones, which would jeopardize their relationships with those loved ones. In this way, the value that FN and P place on their relationship is consistent with the same value that is held by many others in the plague context.

Admittedly, it is not clear that the permissibility of home care follows from this consideration; instead, the permissibility of FN's caring for P is only more probable because many persons in the community identify with the value that FN and P place on their relationship.[50] However, this first level of compatibility issues into a second level, which is expressed as a practical matter of distributive justice. Given that so many community members affirm the value of personal relationships, FN's caring for P in the home context is permissible when, in similar circumstances, any other non-infected person in the plague context is permitted to care for an infected loved one. That is, in light of the factors affecting risk, when my caring for my daughter is not clearly either permissible or impermissible, my caring for her would be justified if the same option of home care is granted to every other pair for whom the risk of home care would also fall into this uncertain margin.[51] Therefore, when respect for the meaning of the relationship between FN and P is compatible with the community's values at these two levels, FN's

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[50] This claim does not depend upon its being the case that anyone in the community has an interest in—or even knows about—the relationship between FN and P. See note 15. Instead, just as someone across town whom I have never met might, like me, appreciate geology and jazz, many others in the plague context might value personal relationships—as FN and P do—without their being acquainted with FN and P.

[51] I am not espousing a general claim of the kind "Behavior B is permissible in a particular case because it is permitted to everyone in similar circumstances." Such a claim would be errant in that there might be other grounds for judging B to be wrong. No, I contend that home care is permitted to everyone in similar circumstances because home care 1) is consistent with the responsibilities that accompany personal relationships, and 2) is not obviously impermissible in light of the risk that it would pose to the community. That is, it seems that home care between members of a personal relationship would be responsible and that there are no other grounds for concluding that it would be impermissible.

caring for P in the home context is morally permissible. This conclusion holds for care relationships for which, with regard to factors affecting risk, our moral judgments are inconclusive.

Implications for Public Health Policies

Above, I argue that home care is morally permissible in two kinds of situations. First, home care is permissible if it would contain risk *at least as well* as would the best alternative, including professional care, if it is available. This judgment focuses on the way in which home care would mitigate P’s risk to the community, thus seeking to respect the interests that all persons have in not being infected. Second, even when it is not clear whether home care would contain risk at least as well as would the best alternative, home care is permissible when it is compatible with the interest that most persons in the community have in maintaining their personal relationships. Each of these judgments has implications for the content of the containment policies that government and health officials should implement for citizens in the plague context.

Public Policy: Moral Permission Because Home Care Limits Risk

In light of the first situation of moral permission, it is clear that containment policies for a plague context should not necessarily prohibit home care. Instead, whether home care should be permitted in a particular plague context depends upon an assessment of the factors affecting the risk that *any* infected person, during home care, would pose to the community. Inevitably, in relationship to an entire population, such an assessment will be a speculative average based on the general features of the plague context that affect risk. As discussed above, these factors include, among others, prevalence of infection, characteristics of community members (e.g. education level), and their use of resources (e.g. pharmaceuticals, masks, gloves). It is plausible that such a general assessment of risks could weigh on the side of moral permission.[52] For example, after the global outbreak of SARS in 2003, the Centers for Disease Control and Prevention (CDC) addressed home care measures for persons infected with SARS.[53] SARS patients, the CDC recommends, should not be taken to hospitals or other clinical facilities unless doing so is medically necessary.[54] Instead, in this document, infected persons are permitted to remain at home with a primary caregiver, and all other family members are advised to reside elsewhere during the patient's illness.[55] In the two narratives that I have imagined, both the VHF outbreak and flu pandemic are more severe than was the recent SARS outbreak.[56] Nevertheless, when risk factors weigh on the side of moral permission, provisions for home care similar to those already made for a SARS outbreak might be made in these plague contexts as well.

Both before and in the midst of an outbreak, there are many practices that government and health officials can undertake in an effort to keep moral permission high and thereby reinforce policies that permit home care. For example, officials might provide the community with access to medicines and non-pharmaceutical resources.

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[52] It is inevitable that some instances of home care would contain risk more effectively than would others, for, again, the conclusion that home care is morally permissible would depend upon averages related to the factors affecting the risk that any infected person would pose to the community. Nevertheless, I assume that a policy that grants moral permission because home care limits risk would grant that permission to any couple that wishes to engage in home care. However, such permission might be revoked if certain conditions (e.g. the relative seclusion of the couple) are not maintained.

[53] See "Supplement D: Community Containment Measures, Including Non-hospital Isolation and Quarantine" (January 8, 2004). Retrieved September 25, 2005, from http://www.cdc.gov/ncidod/sars/quarantine.htm.

[54] "Supplement D," 8.

[55] *Ibid*. In this document, home care is regarded as one kind of "isolation," despite the provision that a primary caregiver stay with the patient in the home.

[56] SARS appears to be less severe than the two viruses that I have been considering. In 2003, of 8,098 known cases of infection, 774 died. See "Fact Sheet: Basic Information about SARS" (May 3, 2005). Retrieved November 29, 2005, from http://www.cdc.gov/ncidod/sars/factsheet.htm.

Furthermore, they might educate the public about both protecting oneself from infection and caring for the ill. One concrete way in which to implement these practices—the distribution of resources and public health education—is by training and commissioning health inspection and care teams. While visiting homes during the outbreak, these teams might provide infected persons and their loved ones with care, supplies, and recommendations, thereby increasing the chance that infected persons will survive while decreasing the risk that these persons pose to others.[57]

When public policies permit home care because it is likely to limit risk, health inspection teams could assume roles that supplement the efforts of primary caregivers in the home. That is, through home visits, by telephone, online, or through some other means, members of inspection teams might advise caregivers regarding the most effective ways to treat their infected loved ones and to protect themselves from infection. However, despite the permission of public policies in these plague contexts, there are likely to be specific cases in which, with regard to risk, our judgment concerning home care would be either inconclusive or that it is impermissible. In these cases, if their intervention is requested, inspection teams might assume a more active role. For example, if a caregiver lacks confidence about the suitability of her home as a care

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[57] The ability of such teams to assist non-infected persons who care for their loved ones might be enhanced if health professionals serve on such teams. With regard to the general efficacy of containment, this approach might be more effective than would be restricting *all* health professionals to the medical facilities at which they are employed. On the other hand, if health workers from areas or nations outside the plague context are willing to serve on these teams, the physicians and nurses who are native to the plague context might retain their responsibilities within medical facilities. Regardless, it is not clear that these teams *should* always include persons who are able to provide care, for that question depends on whether health professionals have an obligation to treat in the plague context. Thus, so as not to imply that these teams necessarily would provide care, I will refer to them as "inspection teams."

environment, she might request the assessment of an inspection team.[58] When, in a particular case, an inspection team judges that home care—even if it is supplemented by health professionals—could *not* contain risk at least as well as would the best alternative, and when policies permit home care *only* on the basis that it is likely to contain risk, it might fall to the inspection team both to remove an infected person from his home and to ensure that he is provided with better care elsewhere.

Public Policy: Moral Permission Because Home Care Respects Community Values

Despite the various efforts of public officials to increase moral permission, the plague context still might be such that the factors affecting risk do not weigh clearly either for or against the moral permissibility of home care. Even in these situations, I have argued that home care is permissible when it is compatible with respect for the value that most persons in the community place on maintaining their personal relationships.[59] It is likely, I suspect, that the value of personal relationships is replete in every society. However, currently, it is obvious that not every society is predisposed to invest its containment policies with the ideal of distributive justice that I have suggested is consistent with moral permission. Consequently, for the latter plague contexts, this argument does not seem to have implications for public policies. In the following section, I speak to such plague contexts. Nevertheless, for societies that are inclined to

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[58] See page 31 of Appendix D3 of "Supplement D" for the CDC's guidelines for evaluating homes and facilities for care. This appendix proposes that most homes of impoverished families in "developing" countries could not meet the "infrastructure" or "resources for patient care and support" requirements.

[59] It is significant to note that there is an additional, economic value associated with home care that is likely to be of interest to most—if not all—members of the community. Home care is, in general, much less expensive than professional care. This economic consideration is an additional reason that a society might be inclined to permit home care.

affirm this vision of justice, this argument might motivate policy makers to incorporate moral permission into the containment guidelines that they develop.

Before speaking to the role of trust in the policy setting that I have proposed, I would like to distinguish this policy from another. If, as I claim, a policy that permits home care would be justified when it is not clear whether such care would contain risk as effectively as would professional care, would a policy that grants moral permission also be justified when it *is* clear that the risk of home care would be *greater* than would that of professional care? If it was clear that home care would not contain risk as well as would professional care, then a policy that permits home care would not be fair to those non-infected persons who, if they become infected, could not permissibly receive home care *because they have no personal relationships*. Such a policy would treat these non-infected persons unjustly in that it would elevate the level of risk that they face for the sake of those who desire to engage in home care. By thus exposing these non-infected persons to danger,[60] this policy would disrespect and jeopardize the goods/pursuits upon which their living meaningfully depends for the sake of respecting a good/pursuit—namely, the opportunity to maintain personal relationships—upon which others' living meaningfully depends. Consequently, I presume that these non-infected persons would not give their assent to a policy that permitted home care when such care clearly would entail a greater risk to both themselves and to the rest of the community than would professional care. In this way, this policy would not be consistent with an egalitarian vision of justice.

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[60] That is, under this policy, these non-infected persons would be exposed to more danger than they would under the three policies that I survey and claim are justified—those of the previous, current, and subsequent sections.

Returning to the policy that I advocate in this section, when a society grants moral permission because it is consistent with the way in which most of its citizens value personal relationships, trust will be instrumental in ensuring that appropriate home care is provided.[61] According to the University of Toronto Joint Centre for Bioethics, trust is a substantive value that ought to inform official decision-making and the development of containment policies that are to be implemented in the event of a flu pandemic.[62] Trust, the report maintains, "is an essential component of the relationships among clinicians and patients, staff and their organizations, the public and health care providers or organizations, and among organizations within a health system."[63]

There are at least three ways in which trust plays a significant role in the interactions between public officials and the population as, together, they seek to provide home care that decreases risk as effectively as possible. First, just as Frank called the city health department to report Paul's illness, officials must trust citizens to report cases—and suspected cases—of infection.[64] In the absence of such reports, the task of assigning inspection teams to assist non-infected persons who care for their infected loved ones

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[61] I suspect that, foremost, it would be a lack of trust/confidence in the competence of citizens to provide appropriate home care that would impel public officials to issue policies that prohibit such care. In their cognizance of the factors that affect the risk that infected persons pose to the community, officials might seek to enhance the trustworthiness of citizens to engage in home care by providing them with the resources (e.g. education, drugs, inspection teams) to reduce the risks that accompany such care. Beyond the provision of resources, the following discussion highlights ways in which policies that permit home care would depend upon a trusting relationship between officials and citizens.

[62] "Stand on Guard for Thee: Ethical Considerations in Preparedness Planning for Pandemic Influenza," (November 2005). This report of the University of Toronto Joint Centre for Bioethics Pandemic Influenza Working Group is available at http://www.utoronto.ca/jcb/home/documents/pandemic.pdf. Retrieved November 29, 2005. Note that the substantive and process values delineated in this report "should be seen as a package of interdependent values that are important in any democratic society" (page 8).

[63] *Ibid*., 9.

[64] With this point, and throughout this section, I am assuming that the values of efficiency and privacy are intact. Otherwise, health officials might mandate, for example, that inspection teams go from door to door, testing the inhabitants of each living space. However, such a policy would be grossly invasive and inefficient in comparison to a policy that encourages and relies upon self-reporting.

becomes much more complicated. It is possible that many citizens, should they fail to report infections and receive assistance, would act irresponsibly in providing an inferior quality of care. In addition, citizens who report cases of infection must trust officials to provide them with the kinds of assistance that have been promised.

Furthermore, in granting moral permission, officials must trust citizens to be cautious as they administer care in the home context. Beyond any official assistance and resources that are provided, the appropriateness of home care depends, in part, upon its ability to keep risk below that level at which home care would be obviously impermissible. Throughout most of the time for which home care is provided, non-infected persons will be alone with their infected loved ones. Therefore, home care can continue to be appropriate only as long as both of these groups consistently avoid negligence and take precautions to avert transmission.

Third, since granting moral permission depends primarily upon the common value of personal relationships, officials must trust citizens to assess their relationships honestly when they consider initiating home care. It would not be appropriate for two persons to engage in home care when each is not committed to the well-being of the other, for, in such a case, the relationship would not be personal in the relevant sense.[65] Of course, it is very difficult for anyone to assess the status of a relationship in which she is not a participant. But this only underscores the need for trust between officials and community members. In their efforts to communicate to the public that care relationships should be personal, officials might describe persons who are permitted to participate in such care

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[65] Consider, for example, two students who have been randomly assigned as roommates in the first semester of college. Although theirs is not a personal relationship, the non-infected student might be inclined to offer to care for her infected roommate, especially if the latter is far away from family and as yet has no friends at school.

as, for example, "close friends or loved ones." Therefore, when home care is permitted on the grounds that it is compatible with the community's interests, it is true that, in several ways, trust between officials and citizens will have an important role in ensuring that appropriate home care is provided.

Public Policy: A Default Prohibition of Home Care

When home care is both unlikely to contain risk and incompatible with the community's ideal of justice, public policy might enact a default prohibition of home care. That is, in this plague context, citizens would be asked to presume that, upon infection, they are not to engage in home care. Instead, infected persons would be asked to receive care in some other way that would contain risk more effectively than would home care; presumably, this would be care from health professionals in designated medical facilities. Thus, in these circumstances, a default prohibition of home care would better respect persons' interests in not being infected than would a policy of general permission to engage in home care. However, in *any* plague context, there might be a reason that public policy should not prohibit home care *categorically*. Home care should not be prohibited categorically whenever there is a method of identifying particular cases in which home care would be morally permissible. For example, inspection teams might be summoned to assess particular cases.[66] In doing so, they might judge that home care is morally permissible in this or that case because of the likelihood that it would contain

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[66] Health officials might make available—via, for example, pamphlets, telephone, and/or a website—a list of criteria that must be met before persons could even request to have a particular case assessed by an inspection team. Unless such criteria are met, the default prohibition of home care would apply.

risk at least as well as would the best alternative.[67]

Despite a *general* assessment that home care is impermissible and a default prohibition, why might an inspection team be inclined to conclude that, in a particular case, home care is justified? One possibility is that the home of FN and P is better suited for care than are the homes of most others in the plague context. For example, their home might be especially clean, have running water, contain sufficient food, and have a stock of care resources (e.g. medicines, masks) to which most others do not have access. They might also have a means of communication (e.g. telephone, internet) with health officials, though most others in the community do not. Furthermore, while there might be few others in the plague context who have a clinical perspective of disease, FN and P might demonstrate a sufficient understanding of the disease and the methods of appropriate care. Some combination of these or other factors might warrant moral permission in a particular case.[68]

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[67] The number of cases for which inspection teams might draw this conclusion is likely to increase significantly if these teams are also prepared to refresh primary caregivers from time to time, supplementing the attention that these caregivers give to their infected loved ones. That is, inspection teams might assist primary caregivers in their homes, giving them an opportunity to rest from the strain of full-time supervision. However, it is unlikely that such assistance would mean that a primary caregiver could leave the home context temporarily, since that caregiver might be infected but asymptomatic and, as such, P's risk to the community would not be limited effectively.

[68] Here, one might object that granting moral permission in particular cases for reasons such as I have listed would be an injustice toward others who are not granted such permission because home care in their cases could not contain risk sufficiently. Thus, such exceptions should not be made, and a categorical prohibition of home care is appropriate when, *generally*, home care is unlikely to contain risk at least as well as would the best alternative. In reply, it is not merely advantageous for a particular infected person and his non-infected loved one when moral permission is granted in their case; instead, permitting home care in their case also benefits the community, for 1) home care in this case would protect the community at least as well as—*and perhaps better than*—would professional care, and 2) permitting home care in particular cases is likely to increase both the accessibility and quality of professional care for others. Regarding this second point, if some infected persons are permitted to receive care in their homes, these persons are not occupying a bed or using other resources in a medical facility, which makes such resources available to others. Thus, granting moral permission in some cases but not in others would not constitute a social injustice; instead, doing so is likely to benefit many others in the community.

When an inspection team is reluctant to grant moral permission in a particular case,[69] there is an additional consideration that, when present, is likely to favor granting moral permission. FN's caring for P is likely to be permissible when there is a non-infected person who is willing to care for FN should FN become infected while caring for P. Primarily, it is *through* FN that P is a threat to the community, for, if P is confined to the home and is in contact with FN more than with anyone else, it is likely that P would transmit his disease to others only by first infecting FN. Generally, of course, persons in the community have an interest in avoiding infection. However, in being willing to care for FN despite the accompanying risks, this particular non-infected person might have interests that take precedence over his desire to avoid infection. By making himself available to care for FN if FN becomes infected, this person provides an additional barrier between P and the community, which reduces the threat that P poses to the community. However, even in consideration of this non-infected person's support, it can only be said generally that FN's caring for P *might be* permissible. This is because it is not necessarily the case that the care of this non-infected person for FN would contain P's initial threat to the community at least as well as would the best care alternative for P. That is, due to the various factors that affect risk, a willing caregiver is not necessarily sufficient to contain risk and merit moral permission. Instead, it is likely that the non-infected person who is willing to care for FN would need some of the knowledge and resources mentioned in the previous paragraph before moral permission could be granted to FN and P.

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[69] When doing so is feasible, officials might institute a means by which a couple could appeal an inspection team's conclusion that home care would not be permissible.

When an inspection team considers the case of FN and P, how might they confirm that there is a non-infected person who is willing to care for FN if she becomes infected? There seem to be two options: either confirm this directly through communication with that person or accept FN's word that it is so. In the first situation, the inspection team might interview the willing caregiver, documenting his understanding and commitment by means of a contract. Such a contract, if it confirms this person's competence to care for FN, would also validate the wisdom of the inspection team's decision to permit FN to care for P.[70] However the inspection team might confirm this person's willingness to care for FN, this is clearly another situation in which trust between health officials and the community would be vital to the effort of protecting the community. If FN was dishonest, or if the candidate to care for FN did not fulfill his commitment,[71] it is likely that an unacceptable level of risk would accompany FN's caring for P.

To summarize, when there is a method—such as inspection teams—of identifying cases of moral permission, containment policies for these plague contexts need not contain a categorical prohibition of home care. Instead, despite a default prohibition of home care, particular cases of moral permission might be identified.

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[70] In confirming that there is a non-infected person who is willing to care for FN, must not the inspection team confirm that there is some additional non-infected person who is willing to care for FN's potential caregiver, *ad infinitum*? Because outbreaks do not last forever, additional confirmations would not be necessary. Instead, confirming only that there is a non-infected person who is willing to care for FN is likely to be sufficient to bring FN's caring for P within the range of moral permissibility, especially since FN might never be infected while caring for P and, for that reason, the additional caregiver would not be required.

[71] Whether there should be legal repercussions for FN's dishonesty or for a candidate's failing to honor such a contract are important questions, but I do not take them up here.

Permissibly Subverting Public Policy

If there is a default prohibition of home care in their plague context, FN and P might know or suspect that moral permission would not be granted in their particular case. In this situation, might there still be an ethically justified way in which FN could care for P in their home context? If FN, when initiating and sustaining care for P, intends to resign herself to isolation if she becomes infected—instead of seeking professional care for herself—her caring for P might be morally permissible. My reasoning here is that, presumably, when moral permission is not granted in a particular case, P would be required to report to a medical facility to receive professional care. The intent of such a policy would be to contain the risk that P poses to the community more effectively than home care could have done. However, by subverting this policy and initiating home care, FN and P have raised this level of risk inappropriately. Thus, if FN is infected while caring for P, it would only be by isolating herself that she could succeed in restoring this level of risk to that which it would have been had she not initiated care and P had gone to a medical facility. For example, if public policy during the VHF outbreak includes a default prohibition of home care, Farheen and Priscus might know that home care would not be granted in their particular case. Nevertheless, Farheen's caring for Priscus might *become* permissible if, by confining herself to the home during care and isolating herself upon infection, Farheen could all but guarantee that she infect no one.[72] In doing so, Farheen would seek to minimize the risk that she and her husband pose to the community. That is, if Farheen isolates herself both during and after caring for her

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[72] Regarding FN's effort to avoid infecting others, I am using the phrases "all but guarantee" and "all but ensure" because it is unlikely that P, had he received care in the best available alternative, would have been entirely ensured of not infecting others. For example, P, had he been taken to a hospital, might have infected a nurse.

husband (e.g. after Priscus dies), the risk that they pose to others would be comparable to the risk that would have accompanied Priscus's being in the district hospital. By isolating herself upon infection, it is likely that Farheen would bring this instance of home care within the range of moral permissibility.[73]

What might it mean that FN isolates herself upon being infected? First, it does *not* mean that she must abandon P, for, aside from the possibility that she could not care for P adequately while she is ill, FN would not endanger P by remaining with him. Instead, she might continue to care for P for as long as possible, staying in the home with him all the while, and remain there for even longer if he should die. Alone in the home after P's death, FN might care for herself for as long as she has strength to do so, struggling to recover. However, practically, whether FN could all but ensure that she did not infect anyone would depend upon many factors, over some of which she might have little control. For example, even if Farheen posted a sign on her door that warned *Harari*! ("Danger!"), an illiterate neighbor might enter unannounced and become infected. Or perhaps an inspection team, hearing a rumor that someone is infected, would visit. Because home care would not have been permissible even with the assistance of such a team,[74] it appears that Farheen must now protect the community by keeping herself beyond the reach of all other caregivers. Only in this way could Farheen bring the risk to others within the range of that which it would have been had she not initiated care for Priscus.

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[73] However, as we have seen, it is unlikely that Farheen would be inclined to isolate herself in an effort to prevent transmitting disease because she does not seem to have a clinical perspective of disease; that perspective, I assume, would entail the most compelling reasons for isolating herself.

[74] In the first paragraph of this section, I assumed that home care was initially impermissible because there was no means—including the assistance of an inspection team—of mitigating the risk of home care so as to make that risk comparable to that of the best alternative.

If FN, infected and isolated, cannot all but guarantee that she does not infect anyone, her act of caring for P could be judged morally permissible only if she takes her own life. This is because, if FN cannot avoid the possibility of her coming into contact with others, suicide would be the only way in which she could bring the risk to others within the range of that which it would have been had she not initiated care for P.[75] Only by mitigating risk in this way could she respect the interests that others have in not being infected. The precise time at which this suicide should occur would depend upon a variety of circumstances. For example, if FN retains a chance to recover and is not likely to come into contact with others, she might be justified in waiting until her strength is waning and it becomes evident that her death is inevitable before she takes her life. However, if FN fears that she cannot avoid contact with others, it might be the case that she should take her life immediately, even if this is before P dies.[76] Whatever might be the appropriate time of her suicide, before taking her life, FN should ensure that health officials are notified and asked to come immediately to collect her body.[77] Only in this

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[75] Imagine that P was aware of the conditions under which FN initiated care for him, and he assented nevertheless. Thus, if P is still alive and cannot ensure that he does not infect others through contact with them, then he, like FN, should take his life to prevent such contact. However, since, as I have argued, it is morally permissible that P decline FN's offer to care for him, it is likely that P would decline if he is aware of the conditions under which FN is offering to care for him.

[76] Again, if P is complicit in FN's caring for him, he should also take his life before coming into contact with others.

[77] It is my understanding that, for many infectious diseases, even the corpse of one who has died from the disease is contagious. This underscores the necessity that health officials be the first to reach the body. If P dies before FN, FN might call for officials to collect P's body while she remains isolated. However, it is more plausible that the risk to others would be kept to a minimum if, before committing suicide, FN called for health officials to collect together both her own body and that of her loved one. If there is a period after which corpses are no longer contagious, and if health officials could prevent others from entering the house, these officials might wait until that period had passed before collecting the bodies.

That health professionals would collect the bodies of FN and P would not change the fact that, under these conditions, home care would contain risk at least as well as would the best alternative, for, under any circumstances, corpses must be collected. Presumably, when collecting the bodies of FN and P from their home, these workers could protect themselves from infection in the safest way that would be available to them in any other situation.

way—if she cannot avoid contact with others—could FN all but guarantee that her caring for P has been morally permissible. Therefore, when FN is infected and either isolates herself or takes her own life, home care might be morally permissible, even when it subverts public policy.

Chapter Two: Obligations to Treat in Times of Plague

Do Health Professionals Have an Obligation to Treat in the Plague Context?

Thus far, my analysis has focused on the risk that P presents to the community and the moral status of home care in relationship to that risk. Regarding public policy, I have argued that home care is permissible in each of two situations: 1) when it contains risk at least as well as would the best alternative, and 2) when, despite the possibility that it is not the most effective means of containing risk, it is compatible with respect for the value that the community places on personal relationships. Generally speaking, when neither of these conditions is met, there should be a default prohibition of home care—though, even in these circumstances, home care might be ethically justified in particular cases that adequately contain risk.

In any plague context, there are likely to be many infected persons who do not engage in home care. For example, persons might refrain from home care because they are honoring a prohibition of home care. In this situation, to whom are infected persons to turn to receive care? Presumably, they are to turn to health professionals, for home care was prohibited because professional care could more effectively contain risk than could home care. However, this seems to presuppose that infected persons in these plague contexts *should* have access to professional care, which raises the question of whether health professionals have an obligation to provide them with such care. Furthermore, consider a plague context in which public policy permits home care for one of the two reasons that I have described; in this situation, there might be many infected persons who either do not have the option of home care—for no loved one is willing to care for them—or who decline that option. In the narrative of the flu pandemic, for example, Frank might become infected while caring for Paul and have no loved one to offer to care for him in turn. Or, augmenting that narrative, Paul might decline Frank's offer of care. In these scenarios, from whom would Frank and Paul receive care? Finally, there might be others who are not infected while caring for a loved one—but who are infected in some other way—and have no loved one who offers to care for them. With these various situations in mind, I ask in this section whether infected persons in *any* plague context should have access to professional care. This question is related closely to another, which is whether health professionals have an obligation to treat infected persons in the plague context.

That I should have access to professional care does not mean simply that it is morally permissible that I enter a medical facility. If this was the case, I might enter a hospital only to find no one there who is willing to provide care for me, and this would render meaningless the notion that I have a right to receive care. Instead, that I should have access to professional care means that there should be health professionals[78] who have an obligation to treat me. Only then *could* my right to professional care be respected—even if, in fact, it is not respected because there are no health professionals who are willing to do their duty and care for me. If I am infected in the plague context, do health professionals have an obligation to care for me?

If health professionals have an obligation to treat infected persons in the plague context, I imagine such an obligation would be one of two kinds—either a standing obligation or a contractual obligation. A standing obligation is one that exists before an

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[78] I say "there should be health professionals" because there being no health professionals to whom I have access would also render meaningless my right to receive medical care.

outbreak and entails that, if an outbreak occurs, health professionals are obligated to treat. If, as a class, health professionals have a standing obligation to treat in the plague context, the source of that obligation is not likely to be any explicit agreement to treat that they make before the outbreak. This is because the specific location and characteristics of an outbreak cannot be known until it occurs; at that time, health professionals would be better disposed to decide whether to care for infected persons in their particular plague context. Instead, a standing obligation to treat might be derived from another source (e.g. ideals of the medical profession, a general oath to practice medicine beneficently). In the absence of a standing obligation, health professionals might enter a contractual obligation to treat. This type of obligation likely would be enacted when, in the midst of an outbreak, health professionals make an explicit agreement to treat infected persons. Thus, because it could be incurred only through the decision of a particular health professional, a contractual obligation is not applicable to health professionals as a class.[79] Instead, it is likely that only some health professionals—if any—would incur this latter kind of obligation.

Before asking whether health professionals have a standing obligation to treat in the plague context, let us examine some arguments that health professionals have a standing obligation to treat in *any* context when confronted with *any* illness that is within the scope of their competence. If there are good reasons to suppose that health professionals have this general, standing obligation to treat, we might then ask whether

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[79] It is true that a health administrator or official might require the health professionals under her supervision to enter a contractual obligation to treat; however, health professionals might resign their posts and avert such an obligation, even if they would incur penalties (e.g. loss of licensure) for doing so.

the same reasons ground their having a standing obligation to treat infected persons in the plague context.

There are many possible sources of a general, standing obligation to treat. These include, for example, 1) the goals and ideals of the medical profession, and 2) a debt that health professionals owe to society. Regarding the former, Pellegrino and Thomasma contend that the goal of medicine is, foremost, “a right and good healing action for a particular patient.”[80] This healing action is what health workers profess to provide, and they claim to have the technical competence to provide it.[81] This claim might be expressed, for example, through a medical oath that health professionals swear. Such an oath “is a public promise that the new physician understands the gravity of this calling and promises to be competent and to use that competence in the interests of the sick.”[82] Of course, health professionals also claim competence implicitly by simply making themselves available to patients. Through this profession and claim, health workers encourage patients to trust them with their illness and to expect them to provide a cure. Pellegrino and Thomasma maintain that this relationship with the patient is the foundation of the moral obligations that health professionals have to patients.[83] Similarly, Ezekiel Emanuel argues that a “physician’s obligations are defined by the professionally and culturally accepted ideals of the profession.”[84] Because healing the sick is primary among those ideals, he concludes that there is in general a standing

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[80] Edmund D. Pellegrino and David C. Thomasma, *A Philosophical Basis of Medical Practice: Toward a Philosophy and Ethic of the Healing Professions* (New York: Oxford University Press, 1981), 219.

[81] *Ibid*., 213-14.

[82] Edmund D. Pellegrino, “Altruism, Self-Interest, and Medical Ethics,” *Journal of the American Medical Association* 258, no. 14 (October 9, 1987), 1939.

[83] Pellegrino and Thomasma, 219.

[84] Ezekiel Emanuel, "Do Physicians Have an Obligation to Treat Patients with AIDS?" *NEJM* 318, no. 25 (1988), 1687.

obligation to treat, for treating the ill is the most effective way in which their healing is accomplished. Individual health professionals do not have a choice to accept or to refuse this obligation, for their entering the profession is tantamount to their accepting it.[85] In this way, the goals and ideals of the medical profession seem to ground health workers' having a general, standing obligation to treat.

Regarding another possible source of a standing obligation to treat, some argue that health professionals have a duty to provide care because treating the ill is a means of repaying the debt that they owe to society. There are various "social contributions that enable physicians to acquire the necessary knowledge and skills" to practice medicine.[86] By sanctioning certain invasions of privacy (e.g. dissecting corpses), contributing financially to medical education, and disclosing medical knowledge accumulated over many generations, society gains and maintains a right to receive care.[87] The "physician's knowledge, therefore, is not individually owned….Rather, the profession holds this knowledge in trust for the good of the sick."[88] Thus, the argument concludes, society's right to receive care corresponds with health professionals' obligation to treat.

No Standing Obligation to Treat in the Plague Context

For the sake of argument, let us grant that health professionals have a general, standing obligation to treat that is at least grounded in both the goals and ideals of their profession and the debt that they owe to society. Are these also reasons to suppose that health professionals have a standing obligation to treat in the plague context? As I have

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[85] *Ibid*.
[86] John D. Arras, "AIDS and the Duty to Treat," *Hastings Center Report* 18 Special Supplement (April/May 1988), 16.
[87] Pellegrino, 1939.
[88] *Ibid*.

described it, the plague context is an outbreak of a highly-virulent, infectious disease; for one who is infected in this context, death is probable. Thus, if the promise to heal and the assurance of technical competence to do so ground the obligation of health professionals to care for patients, then this obligation does not hold whenever health professionals cannot maintain this promise in good conscience. That is, whenever it is probable that persons who are ill *will not be healed* through the care of health professionals—as it is in the plague context—health professionals do not have a standing obligation to treat.[89]

If this claim is correct, one might wonder how it might be *known* that an outbreak is an example of the plague context. In other words, if health professionals have no standing obligation to treat—and, accordingly, they do not treat—how might it be known that persons who are infected are not likely to be healed through their care? First, for some outbreaks, this might be known by comparing the status of knowledge and resources at the time of the outbreak with those of similar outbreaks of the same disease in the past. That is, by evaluating the success of treatment efforts during outbreaks in the past, one might project the potential success of treatment efforts for a current outbreak. When this first method is not feasible,[90] a projection as to whether infected persons are likely to be healed might be made only after *some* health professionals treat and attempt to cure infected persons. Such efforts would be courageous, for, in providing care, these

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[89] Here, I challenge the assumption of the Joint Centre for Bioethics that health professionals would have a "duty to care" during a flu pandemic because "the ability of physicians and health care workers to provide care is greater than that of the public." See "Stand on Guard for Thee," 9. If, despite the best efforts of health professionals, it is improbable that an infected person will be healed, then the ability of health professionals to provide care is not likely to be much greater than that of the general public. Thus, on this point, the Joint Centre's attempt to ground a "duty to care" is insufficient.

[90] The first method might not be feasible, for example, because there are no precedents for the current outbreak—or simply no data from whatever precedents exist—that would serve as viable points of comparison with the current outbreak.

health professionals 1) could not know fully the severity of the risk to themselves, and 2) might be acting outside the scope of a standing obligation to treat. Nevertheless, in providing care, they might increase knowledge of the disease and/or improve methods of treatment, perhaps making healing probable when it otherwise would not have been. To confirm that healing is probable is also to confirm that this outbreak does *not* constitute a plague context and, consequently, that health professionals have a standing obligation to treat persons affected by this outbreak.[91] On the other hand, these professionals might find that, despite their best efforts, healing remains improbable; in this case, such a finding would indicate that this outbreak is a plague context and that health professionals have no standing obligation to treat. Thus, there are at least two ways in which it might be known whether a particular outbreak is an example of the plague context: through either historical comparison or the efforts of some health professionals to treat and cure infected persons during the current outbreak.

Here, one might object that, even in the plague context, health professionals have a standing obligation to comfort those who are infected. As we saw above, the debt that health professionals owe to society is another possible source of a standing obligation to treat. This debt can be distinguished from the goals and ideals of the profession—specifically, from that of healing—for society also provides health professionals with information and resources that prepare them to comfort the sick. Therefore, in the plague context, even though healing is improbable, perhaps health professionals have a standing obligation to comfort and console infected persons. Furthermore, since providing both

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[91] Again, I am assuming that health professionals have a general, standing obligation to treat that is grounded in both the goals and ideals of their profession and the debt that they owe to society. Thus, apart from overriding considerations, such an obligation would apply in this situation.

comfort *and treatment* is not likely to require much greater effort and attention than would giving comfort alone, and given the possibility that treating infected persons would lead to the recovery of some of them, health workers should not merely comfort the sick; rather, they should also treat them. Of course, there might be particular patients for whom only comfort is feasible—for example, cases of medical futility, or when treatment resources are scarce and cannot be allocated to every patient. Nevertheless, it seems plausible that, given their debt to society, health professionals have a standing obligation to comfort in the plague context. Furthermore, there are likely to be many cases in which it would be prudent for health professionals to provide both comfort and treatment in an effort to heal.

To reply, in the absence of a cure for whatever disease gives rise to the plague context, palliative care would be the most common form of care given to infected persons. In medical facilities, such care is provided most often by nurses and others whose training is much less extensive than is that of physicians. Furthermore, the public contributes much less to the training of nurses than to the training of physicians.[92] Therefore, if the public's contributions to the training of health professionals result in their having a debt to society, such a debt would hold to a much lesser extent for nurses and others who would provide the majority of medical care in the plague context than it would for physicians. Thus, for *most* health professionals in the plague context, any obligation to comfort that is grounded in a debt to society would be of a very minimal nature.

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[92] I am thinking of society's investment of knowledge and resources—including money—toward the education/training of these two groups. With respect to the same society, this investment is likely to be much greater for any physician than it is for any nurse.

Furthermore, any standing obligation that health professionals might have to comfort in times of plague would be counteracted by the responsibility of infected persons to protect health professionals from infection. Pellegrino and Thomasma claim that the relationship between health professionals and patients should involve "mutual respect and compassion."[93] The need for such reciprocity is never more evident than in the plague context. Of course, due to their illness, patients are always vulnerable. However, if health professionals have a duty to comfort in the plague context, they are also vulnerable, for every patient encounter would entail exposure to a life-threatening disease.[94] Therefore, the respect and compassion that patients should have for health professionals seem to weigh against the latter's having a standing obligation to comfort. That is, out of respect for the safety of health professionals, society would do well not to ascribe to health professionals any standing obligation to comfort in times of plague.

The Moral Goodness of a Contractual Obligation to Treat in the Plague Context

I have argued that health professionals have no standing obligation to treat in the plague context. In this section, I inquire as to the moral status of a health professional's entering a contractual obligation to treat in this setting. Before doing so, it should be noted that health professionals have no *obligation* to incur a contractual obligation to treat in times of plague, for the former obligation would be a standing obligation and would render the concept of a contractual obligation unnecessary. That is, it is superfluous to say that one should agree to treat infected persons when it is already the

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[93] Pellegrino and Thomasma, 218.

[94] Note here that, while P's risk to the general community decreases as prevalence increases (see the first risk fact on page 21), the risk to any health professional practicing in the plague context would increase as prevalence increases, for that health professional's number of patient encounters is likely to increase as prevalence increases.

case that one has an obligation to treat them. Thus, in the absence of a standing obligation to treat, there can be no obligation to enter a contractual obligation to treat. What, then, are we to say about the morality of a health professional's acquiring a contractual obligation to treat? Would his doing so be morally good, permissible, inappropriate, or blameworthy? In this section, I defend the general claim that a health professional's incurring such an obligation in the plague context would be morally good.

There are several reasons that support the moral goodness of a health professional's contracting to treat infected persons in the plague context. First, the situation of many infected persons is likely to be one of extreme vulnerability. This vulnerability is related to both the nature of their disease and their minimal access to care. For most diseases that would give rise to a plague context, an infected person's symptoms are likely to appear suddenly, quickly incapacitating him and diminishing his ability to care for himself. Thus, if an infected person is to realize his chance to recover, it is likely that he will need the assistance of another. With regard to such vulnerability, Pellegrino contends that a "medical need in itself constitutes a moral claim on those equipped to help."[95] As we have seen, health professionals are qualified to provide comfort; furthermore, in many cases, their attempting to heal would be prudent. These observations become more pressing once we recall that, if not to health professionals, many infected persons would have *no one else to whom they could turn to receive care*. This is because they might have no loved ones—or none who offer to care for them. In the absence of a willing caregiver, an infected person would be alone in his suffering. Therefore, although health professionals have no standing obligation to treat, they might

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[95] Pellegrino, 1939.

protect the vulnerability of such persons by entering a contractual obligation to treat, thereby providing the ill with a refuge of care. Thus, their incurring such an obligation would be morally good.

A second reason that a health professional's entering a contractual obligation to treat would be good is that, in providing such care, health professionals would help to protect non-infected persons who might otherwise have a greater risk of being infected. For example, P might decline FN's offer to care for him, or perhaps P has no one who is willing to care for him; in such cases, by agreeing to treat persons such as P, health professionals would help to shield from infection those who otherwise would have been vulnerable insofar as they might have come into contact with P.[96] Therefore, because their doing so is likely to mitigate the spread of disease,[97] health professionals' entering a contractual obligation to treat would be morally good.

In addition to the goodness of their both treating the vulnerable and protecting non-infected persons from infection, there is another reason that a health professional's entering a contractual obligation to treat would be good. If there are health professionals who already have entered a contractual obligation to treat and are caring for infected persons, it would be good that other health professionals also agree to treat. This is because, in doing so, they would relieve their colleagues of some of the burdens that they shoulder as they provide care.[98] Specifically, by entering a contractual obligation to treat,

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[96] Such persons might include, for example, the mail carrier, persons whom P might ask to deliver food or other supplies, neighbors who stop to see P without knowing that he is ill, etc.

[97] This would be especially likely if health professionals have access to resources (e.g., protective equipment, a sterile environment, a vaccine) to which most others in the community do not, for such resources would greatly diminish their chance of being infected while they provide care.

[98] Arras, 12. Arras makes a similar point when he argues that health professionals should share the burden of caring for HIV/AIDS patients.

health professionals would benefit their colleagues who are already providing care by relieving their workload and further dissipating the risk of infection that they face as they work.[99] Thus, one's incurring a contractual obligation would be good insofar as it is likely to benefit infected persons, non-infected persons, and other health professionals.

A fourth reason that health professionals' entering a contractual obligation to treat would be good is that, in certain plague contexts, their doing so would help to confine instances of home care to personal relationships. I have argued that public policy might permit home care because home care respects persons' interests in maintaining their personal relationships. Furthermore, as we have seen, such a policy requires trust between officials and citizens, for home care is permitted despite the possibility that it would not contain risk as effectively as would professional care. Officials must trust citizens—and citizens must trust one another—to ensure that the relationships that are maintained through home care are appropriately personal in nature. However, as more health professionals accept a contractual obligation to treat, fewer non-infected persons would be motivated by feelings of guilt to offer to care for infected persons who are not loved ones but who have no one else to care for them. This is because, as more health professionals make themselves available to treat, the access that infected persons have to professional care would increase; thus, non-infected persons would be more inclined to help their infected acquaintances seek professional care in medical facilities than to offer to care for them in the home. In this way, a greater proportion of instances of home care are likely to be enacted in the context of personal relationships than would have been

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[99] Here, I assume that, as the number of health professionals who are providing care increases, the number of patient encounters that any health professional has would decrease, thus limiting the risk that is faced by each health professional.

enacted had health professionals not agreed to treat. Therefore, by incurring a contractual obligation to treat, health professionals would help to strengthen the viability of a policy that permits home care out of respect for the value that the community places on personal relationships. That is, health professionals would help to mitigate the number of inappropriate instances of home care.

Finally, a health professional's acquiring a contractual obligation to treat would be good in that, by either working in a medical facility or assisting inspection teams, he would increase infected persons' access to care and the quality of care that they receive. By working in a medical facility, a health professional would increase the access that many infected persons have to care; as more health workers enlist to provide care, more patients can be seen. Furthermore, by assisting inspection teams (i.e. supplementing care in the home context), a health professional would increase the quality of care that many infected persons receive. This might be done in two ways. First, it is likely that, by assisting inspection teams, a health professional would help to bring many instances of home care within the range of moral permissibility when they otherwise would not have been. That is, while the infected person otherwise would have been required to report to a medical facility, now he is permitted to receive care in the home context because such care involves no greater risk than would treatment in a medical facility. Second, in instances of home care that were already morally permissible, a health professional might improve the quality of care that the infected person receives—along with his chances of surviving—by assisting and instructing the primary caregiver in the home. Therefore, by increasing access to care and quality of care for many infected persons, a health professional's incurring a contractual obligation to treat would be good.

In conclusion, I have offered five reasons that a health professional's entering a contractual obligation to treat in the plague context would be morally good. Despite the force of these reasons, it remains the case that, if health professionals have no standing obligation to treat, then their agreeing to treat would be supererogatory; that is, their agreeing to treat would be morally good—and, indeed, praiseworthy—but it is not morally required.[100] Consequently, it is appropriate to understand a health professional's fulfillment of this obligation as an imperfect duty. In other words, a health professional is not required to treat *every* infected person who seeks his care—as he would be if his obligation was a perfect duty—for, when prevalence is high, this is likely to be unfair with regard to both physical strain and the risk of infection that he faces. Thus, a health professional's contractual obligation to treat is an imperfect duty.[101]

It is also important to note that there might be circumstances under which a health professional's entering a contractual obligation to treat would not be morally good. For example, if a physician is solely responsible for the care and education of several children, then his agreeing to treat in the plague context would not be morally good. For this physician to accept such an obligation would involve putting himself at a much greater risk than he is accustomed to, and in this he would be neglecting his

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[100] The claim that there is no standing obligation to treat in the plague context must be temporally indexed, for, due either to the efforts of health professionals who contract to treat or to other factors (e.g. the acquisition of antivirals), that infected persons will recover might *become* probable when previously it was not. In other words, what was once a plague context might cease to be one. Thus, in the absence of overriding considerations, health professionals' general, standing obligation to treat would be relevant in the outbreak, despite their having had no standing obligation to treat when the outbreak was also a plague context.

[101] In fulfilling his contractual obligation to treat, a health professional might, for example, agree to treat infected persons in the plague context for a certain length of time (e.g. two months) and/or to care for a specific number of patients each day so as to mitigate his risk of being infected. By placing such limits on a contractual obligation to treat, it is likely that more health professionals would be inclined to acquire such an obligation, for they would not regard it as over-demanding.

responsibilities to the children who depend upon him. Or consider the case of the only primary care physician at the only hospital in a district that is near the plague context. By leaving her work at the hospital and entering the plague context, this physician would be placing in jeopardy the quality of care that is provided at her hospital in the immediate future and, perhaps, in the long term. For this physician, it is doubtful that her incurring a contractual obligation to treat would be morally good. In short, I recognize the possibility that there might be overriding reasons in favor of a health professional's *not* entering a contractual obligation to treat in the plague context. Depending upon the strength of such overriding reasons, a health professional's disregarding them and acquiring a contractual obligation to treat in the plague context would be either morally inappropriate or morally blameworthy.

No Standing Obligation to Treat: Implications for Outbreak Preparations

I have argued that, in the plague context, health professionals have no standing obligation either to treat or to comfort infected persons; nevertheless, it usually would be the case that a health professional's contracting to care for the ill in this setting would be morally good. If this claim is sound, it has many implications for the ways in which health officials and administrators might prepare effectively for an outbreak.[102] In this section, I address only one of these implications—the importance of establishing the terms and conditions of a contractual obligation to treat in the plague context. Thus, I set aside other, pressing concerns, such as assessing strategies for preparing medical

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[102] I am referring to public health officials at the local, state, and federal levels, and to health administrators of clinics, hospitals, health networks, professional groups (e.g. American Nurses Association), etc.

facilities for an influx of patients during an outbreak, and the issue of reimbursing these facilities fairly for providing such care.

In the plague context, because there is no standing obligation to treat, it would be unfair of health officials and administrators to expect the health professionals whom they supervise to conduct "business as usual." As we have seen, to treat and comfort patients in this setting does not fall within the range of a health professional's pre-existing obligations. Thus, if health professionals appropriately could be expected to provide care in the plague context, it would be only as a result of their having contracted to do so. Establishing the terms and conditions of such a contract before an outbreak occurs is very important, for upholding such a contract is likely to increase the clarity of communication and the quality of care administered during an outbreak. In the midst of the SARS outbreak of 2003, health professionals often worried about the risks they faced; many of these workers were infected, and some died; others failed to report to work and were dismissed for doing so.[103] Perhaps many of these obstacles could be avoided in the plague context if, before an outbreak occurs, the terms and conditions of a contractual obligation to treat are established. Below, I list several items that health administrators and officials might discuss with health professionals in the establishment of such a contract. This catalogue is not intended to be exhaustive.

- Whether any special incentives or rewards will be given to those who agree to treat. For example, they might be offered an increase in salary and/or health coverage for themselves and their family members.
- Measures to protect from infection the health professionals who agree to treat.

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[103] "Stand on Guard for Thee," 9-10.

- Care alternatives that will be extended to health professionals who are infected while caring for others. This might include any compensation that will be given to these health professionals for the period that they are unable to work.[104]
- The length of time for which those who agree to treat will be expected to provide care. This might include any restrictions on the movement of health professionals during the periods that they are not engaged in giving care (e.g. between shifts, after their established term of service has ended).
- Whether those who agree to treat will be released from their contract to provide care in the home context for an infected family member. This might include the circumstances, if any, under which these workers will be expected to return to the medical facility and to continue giving care after they have cared for a family member in the home context.
- Regarding those who do not agree to treat, the terms and conditions of their returning to work—if they will be permitted to do so at all—when their community no longer constitutes a plague context.

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[104] This item and the preceding two points are mentioned in “Stand on Guard for Thee,” 11.

Chapter Three: End of Life in Times of Plague

Home Care and the Dying Stage

At the outset of this paper, I argued that it is during the battling stage of P’s illness that the personal relationship between FN and P remains fully intact. With regard to that relationship, I sought to elucidate the responsibilities that obtain between FN and P during the battling stage. I contended that FN’s caring for P in the home context would be morally permissible—and might legitimately be sanctioned by public policy—in two situations: 1) when it contains risk at least as well as would the best alternative, and 2) when, despite the possibility that it is not the most effective means of containing risk, it is compatible with respect for the value that the community places on personal relationships. However, in the latter scenario, the permissibility of home care is contingent upon the personal nature of the relationship between FN and P; accordingly, we might ask whether FN and P should be permitted to engage in home care when P is in the dying stage and their relationship is no longer personal in the fullest sense?[105] In the section below, I speak to this question.

Public Policy and Less-personal Relationships:

Permitting Home Care in the Dying Stage

I have argued that, as a matter of distributive justice, public policy might permit home care in the plague context out of respect for the value that most persons in the community place on personal relationships. Under this policy, FN’s caring for P in the

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[105] A clinical prognosis that P is in the dying stage means that P’s death is immanent and inevitable—in contrast with his being in the battling stage, when the prognosis is uncertain as to whether he will recover. P’s being in the dying stage means that his relationship with FN is no longer personal in the fullest sense, I have argued, because 1) their hope of maintaining their relationship indefinitely is no longer warranted, and 2) the extent to which each can regard the other’s ends as part of his/her own has been diminished. I assume that both 1 and 2 are significant features of the relationships that we consider personal.

home context is permissible when, in similar circumstances, any other non-infected person in the plague context is permitted to care for an infected loved one. Such a policy would be morally justified, I have claimed, *when it is not clear* whether home care would mitigate risk at least as well as would the best alternative. However, in light of my admission that the relationship between FN and P would no longer be personal in the fullest sense when P is in the dying stage, I have not yet shown that a policy that permitted home care during the dying stage would be justified. In this section, I attempt to provide that justification. If this argument succeeds, it will reinforce my earlier claim that public policy might permit home care—during both the battling and dying stages—out of respect for the value of personal relationships.

First, recall that I have argued *against* a public policy that would permit home care generally when, after a comparative analysis, it is clear that home care would *not* contain risk at least as well as would some care alternative (e.g. professional care). Such a policy, I have claimed, would not be justified insofar as it fails to respect persons who neither have nor value personal relationships, for these persons would face a higher risk than that to which they would assent whenever others in the community exercised their option to engage in home care. For this reason, I begin my argument with a qualification: Generally speaking, if the risk accompanying a non-infected person's caring for an infected loved one *during the dying stage* clearly would be greater than the risk of professional care, then a policy that permits home care generally would not be justified.[106] However, generally, if it remains the case during both the battling and dying

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[106] This is the case even if the risk of home care *during the battling stage* is comparable to that of professional care. For example, when infected persons enter the dying stage, their bleeding—which was

stages that it is not clear whether home care would contain risk at least as well as would professional care, then a policy that permits home care would be justified. This justification follows from at least two considerations: 1) a consistent level of risk to the community, and 2) respect for the meaning of the relationship that survives between infected persons and their non-infected loved ones. Each is addressed below.

If the risk of home care during both the battling and dying stages remains consistent, then a policy that permits home care throughout the course of an infected person's illness would be respectful of the interests that citizens have in not being infected. That is, from the standpoint of non-infected persons, it makes little difference whether P is cared for by FN in the home context or by professionals in a medical setting, for the risk that P poses to the community in each case is roughly the same. This observation is especially significant for those non-infected persons who do not have the option to engage in home care permissibly because they do not have personal relationships. It was with regard to this class of citizens that I balked at a policy that would permit home care out of respect for personal relationships when such care would be accompanied by a higher level of risk than would professional care. However, if the level of risk does not increase during the dying stage—but it remains comparable to that of professional care—then a policy that permits home care during that stage would not fail to respect the goods/pursuits upon which this class of citizens' living meaningfully depends. That is, under this policy, these citizens might continue to study or paint or

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under control during the battling stage—might increase and become uncontrollable for their non-infected caregivers. If the disease in question was blood-borne, this would substantially elevate the risk of home care. Professional care, on the other hand, might be well-equipped to control such bleeding. In this scenario, it seems that home care would not mitigate risk as effectively as would professional care; thus, a policy that permitted home care during the dying stage would not be justified.

whatever they choose without incurring any more danger than they would if their fellow, infected citizens were being care for by health professionals. Therefore, if these non-infected persons—in addition to those who have personal relationships (i.e. everyone else)—could assent to a policy that permits home care throughout an infected person's illness, then such a policy would be justified.

But the foregoing discussion only raises a further question: If an infected person's being in the dying stage results in his having a less-personal relationship with his loved ones, would non-infected persons desire to continue caring for their infected loves ones while the latter are in the dying stage? Assuming that their relationship would retain *some* meaning for them during the dying stage, and assuming that any care alternative would require their being apart when the infected loved one dies, I suspect that most non-infected persons would desire to maintain their commitment to the well-being of their infected loved ones and to continue caring for them until the end. If this is correct, then a policy that permits home care out of respect for personal relationships is justified in that it would respect the health interests and basic values of *all* citizens—both those who have personal relationships and those who do not. This assessment holds even though we acknowledge that an infected person's being in the dying stage would entail that his relationships with his loved ones could no longer be personal in the fullest sense.

Even if the justification above is adequate, it does not follow that a policy that permits home care out of respect for personal relationships also should *mandate* that home care be sustained during the dying stage. If FN and P have access to professional care, and if they can accept their being apart when P dies, I can see no moral barrier to FN's relinquishing P to professional care. In fact, from P's perspective, his receiving professional care during the dying stage might be preferable to home care, for his being in a medical facility and away from FN would be a sacrificial way of protecting FN from himself.[107] Thus, there are reasons that policy should not require that home care, once initiated, be sustained during the dying stage. Below, I consider the possibility of another, morally superior way in which P could protect FN's well-being while P is in the dying stage.

The Dying Stage and the Moral Goodness of Suicide

Once P has entered the dying stage, there is nothing that FN can do to help P recover.[108] Depending upon the status of P's illness, if FN can aid P in any way, she might assist him with basic functions, ease his suffering, and console him with her presence. Thus, in this situation, there remain few ways in which FN could fulfill her commitment to P's well-being. Likewise, every day that P is in the dying stage, he poses a life-threatening risk to FN. He might continue to assent to her care, enjoy her company, and do his best to protect her from himself. Nevertheless, as P nears death, even these possibilities might become increasingly remote. For example, if P becomes incoherent and/or incontinent as he nears death, his abilities to appreciate and protect FN are likely to wane. With these observations in mind, in this section I argue that, under certain

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[107] Here, I assume that FN would consent to this choice. I also assume that FN would not be permitted to remain with P in the medical facility in which P receives care, for FN might be infected by P or by another patient and then threaten the community when she leaves the medical facility. Furthermore, FN's agreeing to remain quarantined with P in the medical facility—and, after P's death, to remain there under observation for symptoms—seems to defeat the purpose of her having admitted P to the medical facility, which was to acquiesce to P's desire to protect her from himself.

[108] The following argument depends upon the assumption that FN and P would know that P is either entering or in the dying stage. Their knowing this would be more likely if there are health professionals who have entered a contractual obligation to treat and who, as members of health inspection teams, are visiting homes in which non-infected persons are caring for infected loved ones. I assume that some of these health professionals (e.g. physicians, nurse practitioners) would be trained to offer prognoses for persons who are infected.

conditions, P’s taking his own life when he is either entering or in the dying stage would be morally good.[109]

Near the beginning of this paper, I aligned myself with John Hardwig’s view that responsible decisions—in a medical context or any other—are those that seek the course of action that will be best for all concerned. I have treated “best” in terms of persons’ well-being, ends or goals, and basic values. As it relates to the plague context, I argued that Hardwig’s position helps us to avoid two errant approaches to decision-making: 1) a patient-focused approach, which fails to take seriously the danger that the patient poses to the community, and 2) a community-focused approach, which, for the sake of protecting the well-being of the community, shows too little consideration for the patient’s interests. With each proposal that I have made, I have sought to hold to the middle course that Hardwig charts between these two approaches. In relationship to the concerns at hand, this is true with regard to my claim that public policy might permit home care during the dying stage of P’s illness. That is, FN is permitted to care for P while P is dying and until P’s disease ends his life. Here, however, *outside the context of justified public policies*, I wish to suggest that there is a morally-superior (i.e. supererogatory) action that P might take when he is either entering or in the dying stage—P might commit suicide. Under certain conditions, P’s taking his own life would be the morally best action with respect to himself, FN, and others in the plague context.

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[109] To avoid complicating my argument, I set aside questions regarding 1) the specific means by which P might take his life, and 2) the moral status of both voluntary active euthanasia and assisted-suicide in this situation. I also avoid identifying a specific time at which it would be most appropriate for P to take his life, for I suspect that “the best time” would vary from case to case. I assume only that 1) P’s entering or being in the dying stage, and 2) P’s being capable of performing this act would be necessary conditions of “the best time.”

P's committing suicide might be responsible with regard to himself if, by taking his life, he would best preserve his core values. Presumably, P values both freedom from suffering and FN's company and care. He also values his own personality and capacities, both intrinsically and because others—such as FN—appreciate them. Thus, if suicide would allow P to avoid a prognosis of such suffering and/or incoherence that he would have been inhibited from maintaining these values, then it is likely that his suicide would be morally good. Regarding the threat of losing one's core values, Hardwig contends that it is more likely that suicide would be a responsible death "when the part of you that is loved will soon be gone or seriously compromised" or "when you soon will no longer be capable of giving love."[110] Larry Churchill concurs that suicide is likely to be morally good when it is, "ironically, undertaken as an avenue of self-preservation, a way of preserving and honoring what is distinctive about one's own life or, at a minimum, a way to avoid a death that is demeaning, humiliating, or diminishes the basic values one has tried to embody."[111] Therefore, if suicide is P's best means of preserving his core values, it is likely that his committing suicide would be morally good.

Above, I advanced the cautious conclusion that, with respect to his core values, P's suicide in the dying stage *is likely* to be good. A more decisive conclusion is not warranted until we have considered the ways in which his suicide might impact FN and others in the community. In fostering a personal relationship with FN, P committed

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[110] Hardwig, "Is There a Duty to Die?" 130. In context, Hardwig is arguing for a duty or obligation to take one's life. For reasons that I will explain, Hardwig's affirmation of this duty is relevant in the plague context only in extreme circumstances, which I will discuss. However, many of the considerations that Hardwig believes inform a duty to die are also relevant to my claim that, under certain conditions, P's committing suicide would be supererogatory.

[111] Larry Churchill, "Seeking a Responsible Death," *Is There a Duty to Die? and Other Essays in Medical Ethics* (New York: Routledge, 2000), 161.

himself to protecting and promoting FN’s well-being. If he persists through the dying stage, there might be little that P can do to uphold this commitment, for FN would be at risk of infection during her days—possibly weeks—of caring for P. If, on the other hand, knowing that he will eventually die from the disease, P takes his own life, he would protect FN from that risk. Thus, if suicide is P’s best means of protecting FN’s well-being, it is likely to be morally good.

However, suicide is *not* likely to be P’s best means of protecting FN unless FN has accepted P’s immanent death and has consented to P’s self-sacrificial act. This is because, with regard to FN’s whole person, the risk of infection that would accompany her caring for P *might be better* than would the grief and despair that she could suffer as a result of P’s suicide. If FN could choose between the two, she might choose the former. In contrast, by explaining carefully his desire to protect FN through taking his own life, P might gain FN’s understanding and consent—perhaps even her gratitude. Such steps could minimize the possibility that FN’s grief over P’s suicide would be more damaging to her well-being than would her grief over his death by disease. Through such a conversation with FN, P could reaffirm both his commitment to FN and the meaning that their relationship has for him: “recovering meaning in death requires an affirmation of connections. If I end my life to spare the futures of my loved ones, I testify in my death that I am connected to them.”[112] Therefore, if FN can understand and accept P’s suicide as his final act of love for her, P’s suicide is likely to be morally good.

Finally, P’s suicide is likely to be good if it would protect the well-being and promote the interests of his community. P’s suicide might accomplish this with respect

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[112] Hardwig, “Is There a Duty to Die?” 134.

to three groups of people: non-infected persons generally, health professionals, and infected persons who are in the battling stage. First, consider non-infected persons in the community. Because it would keep him from infecting FN, P’s suicide would also stem the possibility that P, through FN, would infect others. Thus, by taking his life, P might go some distance toward containing the spread of disease in the plague context. Second, as I have pointed out, P’s suicide and FN’s caring for P in the home until P’s death by disease are not the only options that confront FN and P when P is in the dying stage. Instead, P might seek professional care in a medical facility. Therefore, by committing suicide, P would also avoid endangering the health professionals that would have attended to him had he sought their care. Furthermore, because they would not be caring for P, these health professionals would be more accessible to other infected persons, perhaps increasing the likelihood that such persons would recover. Yet, whether or not they seek professional care, infected persons who are battling disease might benefit from P’s suicide in another way. P might be using resources (e.g. antivirals) that, if he takes his life, would become available to and possibly benefit others. Therefore, P’s committing suicide is likely to be morally good because it would benefit persons in his community in some or all of these ways.

To summarize, in the absence of overriding considerations, P’s taking his own life when he is entering or in the dying stage would be morally good if it 1) would be the best means of preserving his core values, 2) would be the best means of protecting FN’s well-being, and 3) would protect the well-being and promote the interests of others in the plague context. I began by addressing home care and the dying stage in the context of a public policy that permits home care out of respect for personal relationships. However, in the context of a policy that permits home care because it effectively mitigates an infected person's risk to the community, P's suicide might be good *for the same reasons*. This is because, even in this context, P's caregiver in the home might be a non-infected loved one; thus, not only would points 1 and 3 be relevant, but point 2 would be as well. Nevertheless, even when all three considerations are relevant, I have not maintained that P has a moral *obligation* to take his life. In the section below, I propose that such an obligation would arise only when P's infecting another person would be practically inevitable.

When Infection is Inevitable: A Duty to Die

Even in light of the reasons that P's suicide during the dying stage would be morally good, I have not yet contended that P has a duty to take his own life in such circumstances. I have avoided that conclusion for two reasons. First, the dying stage is likely to be a relatively short period of time—perhaps only a day or two or, at most, a few weeks. Within most personal relationships, the expectation to receive a loved one's care for such a short time—especially when one is in dire need—is not out of place. Speaking of care that is given by a family member, Hardwig writes: "Except for short periods of time, it would be *wrong* for any member of my family to devote all her energy or other resources to my care. For that would leave no resources for the care of herself, her other loved ones, or the rest of the family, to say nothing of her responsibilities beyond the family."[113] Closely tied to this point is the recognition that, under most circumstances, FN retains a good chance of avoiding being infected by P. As we have seen, home care should not be permitted unless it would contain risk as well—or very nearly as well—as

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[113] Hardwig, *Is There a Duty to Die?* 170.

would the best alternative. Thus, if FN and P are permissibly engaged in home care, FN retains a chance of avoiding infection; whether or not P recovers, FN's caring for P is not likely to compromise completely her ability to meet other responsibilities after the period of home care has ended. Thus, *typically,* it is permissible for P to accept FN's care for the duration of his dying stage; though his committing suicide would be morally good, he has no duty to die.

Although it usually would be the case that P has no obligation to take his own life during the dying stage, I acknowledge that, in extreme circumstances, he might have such a duty. If P's infecting another person would be practically inevitable, and if committing suicide is P's only way to avoid transmitting his disease, then P has a duty to commit suicide before transmitting his disease. For P to refrain from doing so—especially when, otherwise, he would die from disease very soon—would be for him to disrespect entirely the interests, goals, and well-being of the person(s) whom he would infect. To avoid moral culpability for such disrespect, P should take his own life.[114]

When would P's infecting another be practically inevitable? This might be the case if all locations in which care is being administered in the plague context (e.g. homes and medical facilities) are desperately impoverished of care resources. In this plague context, home care might be permitted because both its quality *and* that of professional care are very low; so, the person at risk of infection might be either a loved one or a health professional. In the home or a medical facility, if the dying stage was accompanied by uncontrollable hemorrhaging, for example, P might pose such a high risk

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[114] This duty to die is, I wish to maintain, *only a moral duty*; it is not an obligation that should be exacted from P by legal measures such that, if he failed to fulfill it, he would be subject to criminal punishment. Furthermore, I do not speak to whether criminal punishment would be appropriate if P is knowingly and actively infecting others.

either to a loved one or to health professionals that his only means of avoiding transmitting his disease would be to take his own life.[115] Therefore, a duty to die could arise for P whether he is in the home or in a medical facility.

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[115] Even if P could avoid infecting others by isolating himself—which might not be possible if his body was discovered and/or not collected cautiously—suicide might be preferable to P's dying in a medical facility, for, if P is receiving home care, both P and FN might desire to be together when P takes his life.

Chapter Four: Public Health Policy in Times of Plague

Successful Health Policy: Social Integrity through and beyond the Plague Context

Insofar as health policies set goals for social well-being, values necessarily inform their content. For example, the WHO's policy recommendations for strategically countering a flu pandemic are designed "to reduce morbidity, mortality, and social disruption."[116] Thus, if "success" is determined relative to a designated set of values, a health policy is successful to the extent that it guides the society for which it is designed to realize the values identified in that policy. For example, also regarding pandemic flu, a working group at the University of Toronto's Joint Centre for Bioethics identifies ten substantive values and five procedural values that, it believes, can guide ethical decision-making both before and during an outbreak.[117] These, in addition to the other values that this group identifies, are said to be "important in any democratic society."[118] Thus, to the extent that these values are expressed by public health measures (e.g. quarantine) that are sanctioned by policies structured upon the Joint Centre's recommendations, these policies would be successful.[119]

Although I agree that the values identified by the Joint Centre's working group are important in any democratic society, this group seems to have overlooked the widespread significance of personal relationships. Both forming and maintaining these

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[116] "Responding to the Avian Influenza Pandemic Threat: Recommended Strategic Actions," World Health Organization (2005), 1; 13. In seeking to mitigate "social disruption," it is clear that the WHO is concerned, in part, with avoiding as much as possible the temporary paralysis of "public services and economic productivity." See page 13. Some national contingency plans for responding to pandemic flu follow the WHO's recommendations and identify with its stated values. See, for example, "UK Health Departments' Pandemic Influenza Contingency Plan" (October 2005), 6.

[117] "Stand on Guard for Thee," 6.

[118] *Ibid*.

[119] Personal communications with Peter A. Singer and Ross Upshur, who are among the authors of "Stand on Guard for Thee," (March 2006).

relationships are compatible with many of the working group's substantive values (e.g. trust, individual liberty, privacy).[120] Yet, during an outbreak, to permit a contagious individual to maintain a personal relationship with someone who is not infected would *seem* to conflict with another of the working group's substantive values (e.g. protection from harm). As we have seen, however, there are two general situations in which the value of personal relationships—as expressed through home care—does *not* conflict with the value of promoting public welfare: 1) when FN's caring for P in the home context would contain risk at least as well as would the best care alternative, and 2) when it is not clear whether the risk of home care is greater than is that of the best care alternative.[121] I have argued that home care is morally permissible in each of these situations because it respects the community's interest in avoiding infection. In the plague context in particular, preserving personal relationships is especially critical, since, in this setting, it is probable that P will die from his disease, losing his relationship with FN. Consequently, both P and FN have a strong incentive to maintain their relationship during the course of P's illness, for FN's relinquishing P to professional care is likely to be, for these two, an act of final separation.

I have contended that the two judgments above regarding the moral permissibility of home care have implications for public policies in the plague context. The second situation, in particular, is relevant for democratic societies whose vision of distributive justice is egalitarian. In such societies, personal relationships might appropriately inform public health policies because, under certain circumstances, the opportunity to maintain

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[120] For descriptions of these values, see "Stand on Guard for Thee,"6-7.

[121] These assessments of the risk of home care would be based upon a comparative analysis of the quality of each of P's care alternatives.

such relationships is extended to all citizens. Due to its importance to society, the value of personal relationships might be upheld justifiably, despite the possibility that home care does not contain risk as effectively as would professional care. Therefore, health officials in democratic societies should not be too hasty to separate citizens by imposing quarantine or isolation measures upon them, for their doing so might 1) be unnecessary for protecting the public from harm, and 2) disrespect a good to which most—if not all—persons in the society assent. Such hasty measures would be the result of officials' advocating what I have called a community-focused approach to medical treatment and health policy. Although believing themselves to be protecting the well-being of the non-infected community, officials operating under this approach would be disregarding the interest that infected persons have in maintaining their relationships with loved ones. Thus, in the second situation above, the fact that the value of personal relationships is compatible with that of promoting public welfare can be translated into public health policy.

In a significant portion of this paper, I have sought to show how a family-centered approach to treatment—which seeks a decision that will respect the interests and values of all whom it will affect—can be amplified and deployed in the arena of public health policy. By adopting this approach with regard to the plague context, I have provided a model for its use in other public health contexts. If the composite of the substantive values of a society is analogous to that society's integrity, then the potential for the success of the family-centered approach rests in its ability to preserve a society's integrity both through and beyond any particular public health context.

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Vita

Michael Woods Nash was born on September 1, 1981, in Glasgow, KY, where he attended Glasgow High School. He received a B.A. from Cumberland College in 2004, completing Presidential Scholars Research in his major field (Philosophy/Religion). He graduated summa cum laude and was the honored graduate in Philosophy. He is pursuing the Doctor of Philosophy with a concentration in Medical Ethics at the University of Tennessee, Knoxville. He is preparing for a career in health care management.