

Bioethics and Infectious Disease



Professor Lucy Allais

Bioethics is a relatively young field, beginning, in the USA, in the 50s and 60s, maturing in the 80s and 90s.

This is different to both medical ethics, and ethics generally.



Medical ethics

Reflections by doctors and societies on the ethics of medical practice is probably as old as doctoring (Hippocratic oath; the Code of Hammurabi, written in Babylon in 1750 BC).

Traditionally focussed on the doctor-patient relationship and the virtues possessed by the good doctor. (Kuhse and Singer *A Companion to Bioethics* 2001:4).

Ethics in philosophy:

Morality: how should we live? what is right? what is wrong?

Ethics: the academic study of morality.

Are there objective values?

Are there truths about right and wrong?

What makes actions wrong?

How do we resolve moral disputes?

What is the basis of human rights?

When is euthanasia permissible?

Is it morally justifiable to incarcerate MDR TB patients?

Why did bioethics develop in the late 20th century?

New, morally disruptive technologies:

Artificial ventilators; organ transplants; contraception; in vitro fertilization; pre-natal testing; genetic technology.

Civil rights movements; human rights:

Questioning of doctor authority; patient rights; nurses.

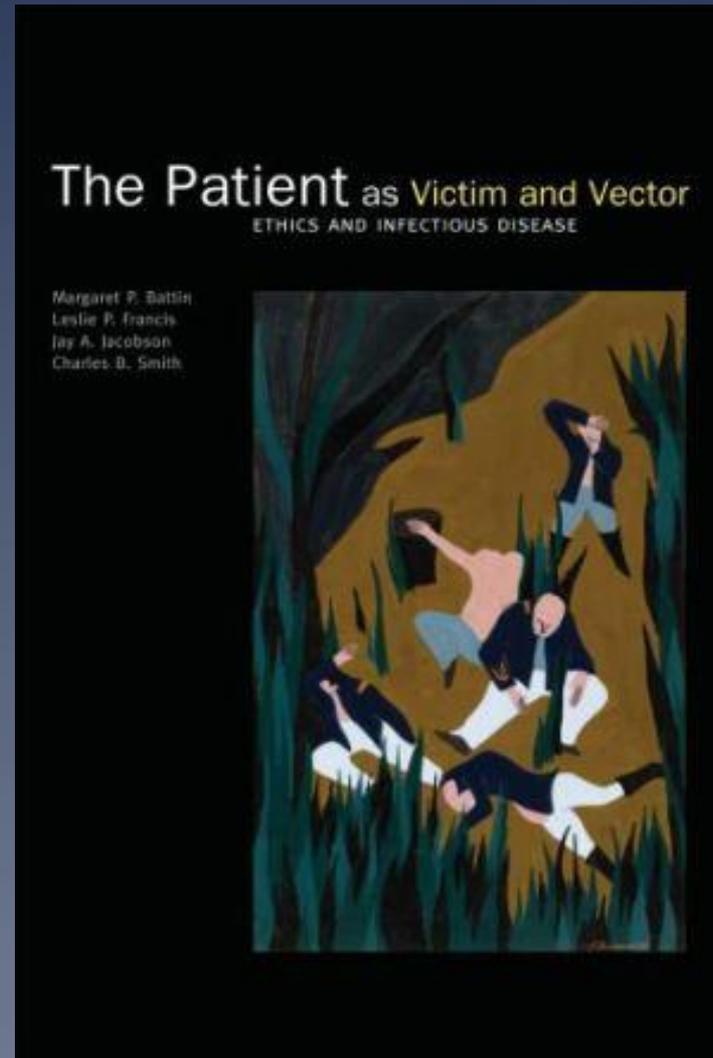
The lack of regulation in the USA (Baker, *Before Bioethics*, 2013).

The new field of bioethics was interdisciplinary from the beginning, involving doctors, nurses, lawyers, philosophers, theologians, economists, public policy.

The development of ethics text books for medical students: the four core values of **autonomy**, **justice**, **beneficence** and **non-maleficence**.

The time and place in which bioethics was developed resulted in it, for most of its formative years, paying disproportionately little attention to infectious disease.

The Patient as Victim and Vector: Ethics and Infectious Disease, Battin et al, OUP 2009



‘In March 2005, for example, a google search of the phrase ‘ethics and infectious disease’ yielded only 35 entries, while ‘ethics and genetics’ yielded 5100’ (Battin et al p 49).

A PubMed search in April 2008 found: ‘5249 entries for ‘ethics and abortion’, 10140 for ‘ethics and euthanasia,’ and a paltry 87 for ‘ethics and infectious disease.’ (Battin et al p 49).

New, morally disruptive technologies: ethical reflection on the implications of these technologies for individuals.

Civil rights movements: emphasis on individual autonomy.

The new field of bioethics was initially focussed on a concern to protect the rights and choices of individual patients and the ethical implications of the new technologies.

Bioethics developed in the USA: optimism about the end of infectious disease.

In the formative years of bioethics, in the US, infectious disease was seen as a problem of the poor, in other countries, and thought to be soon a thing of the past.

Some time in the 70s the US surgeon general is reputed to have said that it is time to close the books on infectious disease....

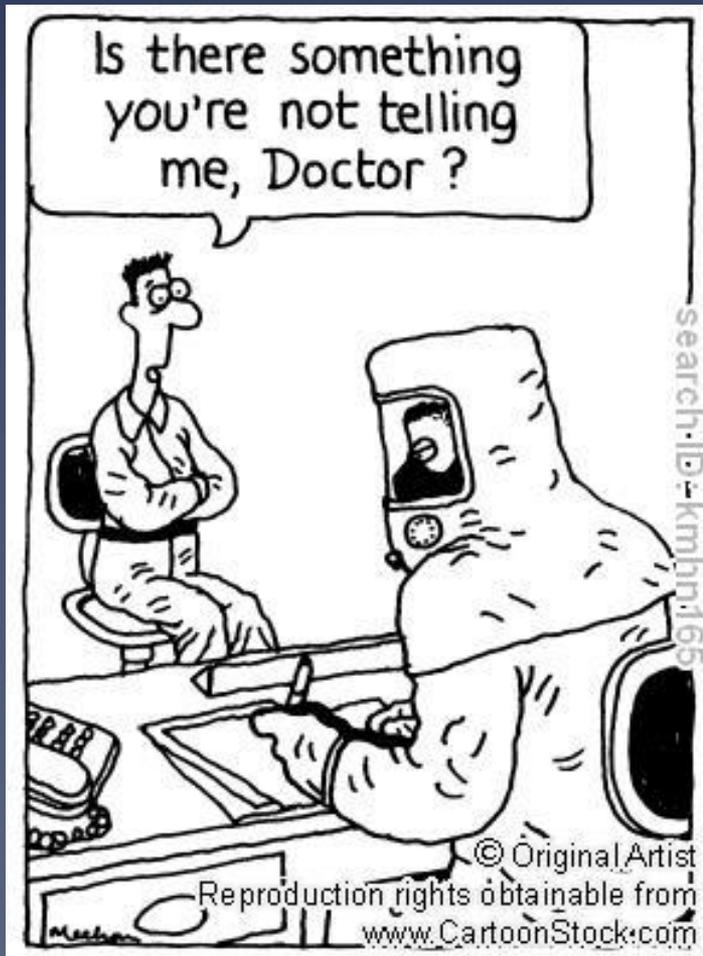
...malaria; TB; HIV; SARS; CJD/BSE; failures of anti-biotic stewardship potentially taking us back to a pre-anti-biotic age; hospital acquired infections; anthrax used as a weapon of terror; the implications of breakdowns in rubbish collection and sewerage processing; recent outbreaks of previously controlled serious diseases such as whooping cough in the US due to poor vaccine coverage; the effect of climate change on distribution of insects, the nature of water reservoirs and the movements of displaced populations....

Infectious diseases are responsible for more morbidity and mortality than any other cause in history, including war (Selgelid 2001).

“The Black Death eliminated one-third of the European population in just a few years during the mid-fourteenth century; the 1918 flu epidemic killed between 20 and 100 million people; and smallpox killed between ... three times more than were killed by all the wars of [the twentieth century]” (Selgelid 2001: 430)

It is intrinsic to infectious disease that an individual's having it has implications for others.

Patients can provide a risk to their communities and to health care practitioners; health care workers can pose risks to patients.



Infectious disease highlights our biological vulnerability to each other, and our biological dangerousness to each other.



‘human beings live together with each other in a web of potential and actual disease, all the time, even when they are not currently overtly ill and not aware of the possibility of transmission’ (Battin et al p 80). This is not something over which we have choice, and not something we can entirely control.

“All human beings are potentially (and often actually) both *persons-in-need* and *persons-as-threats*’ (Battin et al p 8).

Anti-biotic stewardship: duty to *this* patient; duty to the community; duty to future people; duty to this patient's future self.

A parent may often judge that a 15 % chance of two days quicker recovery is worth it (suppose the child has a big sports match; suppose the parent has no child care).

Restrictions of liberty?

You aren't allowed to take a gun on a plane.
Should it be illegal to get on a plane with MDR
TB?

Should you be allowed to get on a plane with
influenza?



You don't have the right to choose to do whatever you want with your garbage.

What about vaccines? Are people entitled to refuse to defend themselves if this refusal may threaten others?

Should medical practitioners be required to have influenza vaccines? Battin et al ask: is treating patients while drunk, or not keeping up your skills, different from potentially endangering them with your infection?

How do we plan ethically for pandemics?

Infectious disease does not respect national boundaries; it raises questions of international law and international justice.

HIV as exceptional?

The role of human rights activism in the epidemic.

Both spreading and acquiring HIV is more directly under individuals' control than is the case for most infectious diseases.

Battin et al argue that infectious disease does not just bring up new problems, it challenges the way we understand concepts bioethics appeals to, like **autonomy**.

They argue that bioethics has had a too individualist approach to autonomy. They argue that we need a way of thinking about decision-making in relation to infectious conditions that sees people in more relational terms, rather than as isolated individuals making choices only for themselves.

In the liberal tradition, autonomy is understood in terms of individual choice, and the right of individuals to make decisions for themselves.

Health is a very intimate, personal matter, and making decisions about your health and your body for yourself might seem to be one of your most fundamental rights.

But, as we have already seen, it is intrinsic to infectious disease that decisions are never just about the individual alone, and have implications for others, including implications about endangering others.

What about public health?

Public health: traditionally utilitarian, the general good.

Neither a purely utilitarian, community-good public health perspective nor an individualistic autonomy-based perspective will solve the problems raised by infectious disease.

Alternating between these extremes will lead to lurching between fear-induced overly restrictive policies, and individualist approaches that fail to take sufficiently seriously how people can endanger each other.

We need to rethink autonomy and rights.

There are ways in which public law limits our choices that are not best understood as limiting autonomy, because they enable our freedom (public roads).

Rights are enforceable entitlements; they require a state.

Requirements that are placed on us that are necessary for all of us to be able to live together do not constitute a violation or a limitation of autonomy.

Public law concerning water purity and garbage collection is a important to protect us against infectious disease. No one has a right (an enforceable entitlement) to do what they want with their garbage.

Anti-biotic stewardship:

It is important for all of us that we don't run out of anti-biotics.

It is important that doctors act in the best interests of their individual patients.

We can't solve the problem by expecting doctors to weigh up the general good against the good of their individual patient. We need a regulatory framework that makes it much harder for doctors to prescribe antibiotics (this would protect doctors from pushy patients).

Anti-biotic stewardship:

Restricting our access to anti-biotics would not be a limitation of our rights. We don't have a pre-existing right to always have the quickest possible cure available, no matter what the cost to others, and restricting our access to anti-biotics is necessary to protect all of us.

Vaccines: do you have a right to refuse a very small risk to yourself, if it endangers others?

Do you have an enforceable entitlement never to bear any risks?

If each of us bearing some minor risks is the cost of all of us living safely together, then we do not have an entitlement that we do not do so.

At the same time, we do not have an enforceable entitlement never to be exposed to dangers.

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