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The duty to care in an influenza pandemic: A qualitative study of Canadian public perspectives

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ABSTRACT

Ever since the emergence of SARS, when we were reminded that the nature of health care practitioners' duty to care is greatly contested, it has remained a polarizing issue. Discussions on the nature and limits of health care practitioners' duty to care during disasters and public health emergencies abounds the literature, ripe with arguments seeking to ground its foundations. However, to date there has been little public engagement on this issue. This study involved three Townhall meetings held between February 2008 and May 2010 in three urban settings in Canada in order to probe lay citizens' views about ethical issues related to pandemic influenza, including issues surrounding the duty to care. Participants included Canadian residents aged 18 and over who were fluent in English. Data were collected through day-long facilitated group discussions using case scenarios and focus group guides. Participant's views were organized according to several themes, including the following main themes (and respective sub-themes): 1. Legitimate limits; a) competing obligations; and b) appeal to personal choice; and 2. Legitimate expectations; a) reciprocity; and b) enforcement and planning. Our findings show that participants moved away from categorical notions of the duty to care towards more equivocal and often normative views throughout deliberations. Our analysis contributes a better understanding of the constitutive nature of the duty to care, defined in part by taking account of public views. This broadened understanding can further inform the articulation of acceptable norms of duty to care and policy development efforts. What is more, it illustrates the urgent need for policy-makers and regulators to get clarity on obligations, responsibilities, and accountability in the execution of HCPs' duty to care during times of universal vulnerability.

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Introduction

In the wake of global communicable disease outbreaks, such as the 2009–2010 H1N1 influenza pandemic and the outbreak of severe acute respiratory syndrome (SARS), and other public health emergencies of the past decade, we are reminded of the risk front line health care practitioners face in contexts of contagion and, more crucially, of the challenges of defining their duty to face those risks. So too for front line health care practitioners (HCPs) who face disproportionate risks of serious morbidity and mortality from infection (Ruderman et al., 2006), leading us to question the boundaries of their duty to care. Ever since SARS when Singer et al.

(2003) emphasized that the nature of HCPs' duty to care is historically and philosophically contested, it has remained a polarizing issue.

There has been an ongoing debate surrounding the nature of HCPs' duty to care and over the years there has been a continued evolution of perspective. Broadly speaking, the positions on the extent of an HCPs duty to care has, on the whole, moved from the more absolute and categorical to a more nuanced position. The mid-19th century American Medical Association Code of Ethics was among the first to formally introduce the concept of a physician's duty to care and did so in near-absolute terms by stating that, "[w]hen pestilence prevails, it is [physicians'] duty to face the danger, and to continue their labors for the alleviation of suffering, even at the jeopardy of their own lives" (Baker, Caplan, Emanuel, & Latham, 1999, p. 40). Today, however, while there is continued acceptance of a duty to care on behalf of HCPs, few use as strong of language as does the 1847 Code. Indeed, there has been a consistent recognition

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that considerations of personal welfare may indeed impose limits on HCPs' duty to care. As Norman Daniels puts it, we find the 1847 AMA Code as being "too extreme" and, he argues, "that there are some limits, however vaguely specified, to the risks physicians have agreed to face" (Daniels, 1991, p. 38).

However, the question regarding the specific nature of the obligations faced by HCPs and just how to define the limits to risks to which HCPs agree, if they do at all, remains. This polemic is especially relevant in the context of an influenza pandemic, where it would be virtually impossible to determine what constitutes a standard level of risk. Ought we not, however, strive to establish the conditions and parameters defining HCPs' duties and obligations during an influenza pandemic?

Discussions on the nature and limits of HCPs' duty to care during disasters abounds the literature, ripe with arguments seeking to ground its foundations. Indeed, numerous scholars have explored the foundational nature of the duty to care, grounding it in the social contract (Clark, 2002, 2003; Loewy, 1988; Sharp, 1988), views of community, justice, and professionalism (Freedman, 1988; Loewy, 1988; Sharp, 1988; Wynia, Kurlander, & Green, 2006), the dependent nature of the patient (Sharp, 1988), concepts of duty and courage in the medical setting (Loewy, 1986), codes of ethics (Baker & Emanuel, 2000; Sharp, 1988; Sohl & Bassford, 1986), public trust (Clark, 2002, 2003; Wynia et al., 2006), the healing role of the provider (Angoff, 1991), common humanity (Sheldon, 1990), the understanding of medicine as a moral enterprise (Zuger & Miles, 1987), the virtues of the health professions (Arras, 1988; Zuger & Miles, 1987), the ideal of self-sacrifice (Arras, 1988), the view that it is a core obligation of professionalism that is both intrinsic (Sharp, 1988) and/or necessary (Wynia & Gostin, 2004), presumed consent (Civaner & Arda, 2008), as well as arguing that a duty to care follows from a robust interpretation of the 2001 AMA Code of Ethics because it constitutes a minimal moral standard of conduct for physicians as professionals possessed of special abilities and expertise (Clark, 2005a).

Wherever one stands on this issue, few challenge the view that some degree of duty, however defined, exists, and that it does, in times of broader social emergencies, trump an HCP's autonomous right to refuse provision of care. Therefore, the pertinent question regarding the duty to care shifts from "whether or not" to one of "when and to what extent" (Clark, 2005a). Thus, to increase understanding of this issue, we must go beyond assessing (that is, making a case for) whether a duty to care exists during disasters, but rather focus our theoretical, empirical, and policy efforts on further bolstering our understanding of the scope and limits of a duty to care. Some attempts have been made in this direction: on an empirical basis (Balicer, Omer, Barnett, & Everly, 2006; Bensimon, Tracy, Bernstein, Shaul, & Upshur, 2007; Draper et al., 2008; Ehrenstein, Hanses, & Salzberger, 2006; Seale, Leask, Po, & MacIntyre, 2009); based on legal jurisprudence (Davies & Zlotnik-Shaul, 2009; Walker, 2002); on a conceptual basis (Clark, 2005b); or on a philosophical account (Ruderman et al., 2006; van der Weijden, Bredenoord, & van Delden, 2010). Policy-makers themselves have been spurred by the practical challenges caused by the lack of guidelines regarding duties and obligations during pandemics. Many regulatory bodies too have taken heart, largely in response to the distress this caused during SARS, by addressing the need to define what the duty to care means in practice, especially during disasters or public health emergencies.

So while recent disasters have stimulated debate among scholars and policy-makers about the duty to care, there has been little engagement with the public on this issue. In a previous study conducted by our research team, we sought to describe lay and expert views on the duty to care in the aftermath of SARS (Bensimon et al., 2007). As part of its research platform, which

included different forms of stakeholder engagement and national telephone surveys, the Canadian Program of Research on Ethics in a Pandemic (CanPREP) built on this study by conducting three Townhall meetings across Canada in order to probe participants' views about ethical issues related to pandemic influenza, including issues surrounding the duty to care. A related goal was to enhance the legitimacy of the substantive and procedural values proposed in the University of Toronto Joint Centre for Bioethics' seminal report on ethics during a pandemic, which had been developed without public input (University of Toronto Joint Centre for Bioethics Pandemic Influenza Working Group, 2005). Public engagement on matters of practice and policy, we believe, lends inherent authenticity to the burgeoning policy area and newly-developing standards of practice pertaining to the duty to care during disasters. In this paper, we present findings from the Townhall discussions on the duty to care with the view of further bolstering our empirical understanding of its scope and limits.

Methods

Participants and settings

The team conducted three Townhalls in three major Canadian urban settings. Canadian residents aged 18 and over who spoke fluent English were recruited from the general public using local newspapers advertisements and online social networking sites. In addition, study collaborators (i.e. local contacts that assisted in setting up the Townhalls) used snowball sampling to recruit participants in their local areas. A total of 30 participants attended. The study received ethics approval from the University of Toronto. All participants provided written consent prior to participation.

Data collection and analysis

Data was collected through day-long facilitated discussions using case scenarios and focus group guides (Appendix 1), which were developed collaboratively by the research team. At each Townhall meeting, participants were randomly divided into groups of five to ten people and asked to deliberate on the ethical issues concerning an assigned scenario (see Appendix 1), in this case the duty to care. Groups met in the morning and afternoon (approximately 8 h) and were both given new details on the case and asked a new set of questions as deliberations progressed (see Appendix 1 for "reveals"). At the end of the day, the four scenario groups met together to debrief and share the key issues raised and discussed in their small groups. While the CanPREP team is disseminating results with regard to all the research areas, this paper reports only the results from the duty to care group from the three Townhalls. Group discussions were facilitated by a member of the team while another member took notes; Townhalls were audio recorded, transcribed verbatim, and verified by team members.

Data analysis

We conducted a thematic analysis of each transcript within and across Townhalls according to standard qualitative analysis procedures. Thematic analysis progressed via the following four steps: 1) Each member of the research team coded each transcript independently, one Townhall at a time; 2) A shared coding framework for each Townhall meeting was developed collectively based on each individual's independent codes; 3) Codes were collapsed into themes for each Townhall, repeating the process for all three Townhalls; and 4) Themes were generated collectively across Townhalls.

Trustworthiness of our analysis was ensured by standard qualitative criteria such as prolonged engagement with the data by research team members both individually and as a group, and a series of peer consultation and peer debriefing sessions (Lincoln & Guba, 1985). Members of the research team met regularly at each stage of analysis in order to discuss the interpretation of the results and consider the emerging themes. We also presented and discussed our results with the larger CanPREP research team. Finally, we kept detailed team notes at each stage of analysis of what codes were added, removed, or collapsed in order to establish an “audit trail” (Guba & Lincoln, 1994). The study received ethics approval from the University of Toronto.

Findings

Participant’s views were organized according to several themes. We will focus on two main themes (and respective sub-themes): 1. Legitimate limits; a) competing obligations; and b) appeal to personal choice; and 2. Legitimate expectations; a) reciprocity; and b) enforcement and planning.

Legitimate limits

Competing obligations

After reading the scenario and upon being asked the first set of questions (e.g. What are your initial thoughts and feelings about this?), participants homed in on what they understood to be the core conflict that HCPs face when it comes to the question of the duty to care: that of divided loyalties stemming from competing obligations (professional, familial, citizenship, cultural, etc.). It was repeated several times that HCPs have “multiple concerns”, “multiple responsibilities”, and “a dilemma.” Perhaps given that most of us assume many roles all at once, as one participant noted, many said that they could “relate” and granted that it was a “murky situation” with “no easy answers” that “has to be tackled somehow.”

Despite immediately expressing ambivalence, however, many participants first favoured the view that the duty to care “overrides” all other concerns; or, put another way, that the “duty to provide” or the “duty to save” came first. As one participant asserted: “You’re in that profession and emergencies are part of it, whether you like it or not.” Or as another participant stated, “she [physician] has a moral obligation to go to work.” Some participants greatly emphasized that it is a moral obligation by virtue of the oath physicians take: “He took an oath; he chose that as a profession.” Reflecting the view of many, one participant asserted that it is an obligation, moreover, because “risk is inherent to the profession” that HCPs “know beforehand.” As one participant said: “She’s [physician] already working in a place where you are exposed to things.” While one participant conceded that it was “a tough situation,” she said bluntly that Maria (the first physician in the scenario) is “working in a place where you are already exposed, bottom line.” Or another said: “You can’t just refuse to show up at work [because of that].” Referring to the male physician in the scenario, a participant commented that if he is already “providing care with an existing illness, there’s no reason to stop” during a pandemic, thus arguing that we should not draw a distinction whether there is a pandemic or not.

In addition, another argument in favour of an unwavering duty is that HCPs, like all citizens, ought to “sacrifice their individual liberty” in times of crises to support the “greater good”. In support of that view, one participant stated: “In an emergency, that’s just the way it goes—rights have to necessarily go out the window.” Another participant, who disagreed with that point, nonetheless

thought that “it [would be] selfish not to favour your professional role.”

Through the course of the discussions, however, participants expressed a more nuanced view, fostered through deliberations, as they were challenged to rethink their position with each new reveal (see Appendix 1). With that, nearly every participant, even those whose starting point was more categorical, arrived at the conclusion that the eventual solution lay somewhere between positing an absolute duty and abdicating the duty altogether. That is, it is a duty with limits *as long as* there is a legitimate reason. In other words, the vast majority agreed, “It is unjustifiable [not to provide care] if one doesn’t have a bonafide reason” or “you would have to have a *really* good reason [not to provide care].”

While the view that there are limits to the duty to care was widely shared, what was less agreed upon, however, was what counts as a legitimate limit. While most agreed that “extenuating circumstances” are legitimate limits, there was a wide range of views as to what constitutes such a circumstance: from one’s own health: “If someone has an existing illness, then there is no conflict” or “If your health is compromised, it’s a good enough reason to say no”; to family constraints: “She’s [physician] not going to be any good at work if she’s dealing with a crisis at home” e.g. child care; or the impact on family: “Her [physician] family is a priority, despite the potential for loss of license [if she doesn’t show up to work]”; to inadequate personal protective equipment: “[They] need to be safe in order to help others” or “You can’t provide good treatment without proper equipment” or “HCPs are sworn to provide care; if they don’t have the proper equipment, there’s no point”; to fear “If he’s [physician] afraid, he’s no good” or “fear trumps everything.”

Appeal to personal choice

While participants explored together what constitutes a legitimate limit (“How do you define a good reason?”) and considered how one ought to balance competing obligations (“There is a really big pull in [many] directions”), many appealed to personal choice as being fundamental to the understanding of the duty to care. One participant affirmed: “I have to stress; it’s her [physician] choice if she wants to stay home – even if her workplace will suffer.” Or another asserted: “It is a personal choice; it is justifiable to say no.”

Significantly, participants felt that what constitutes an acceptable level of risk is based on a given individual’s notion of what is safe or acceptable. For this reason, HCPs should be protected according to “their comfort level” because, as one participant observed, “what you [pointing to someone in the room] see as dangerous is different than what you [pointing to someone else] see.”

The view, however, that one can simply appeal to personal choice was challenged by the view that it ought be “restricted based on legitimate limits.” So while personal choice was thought to be fundamental, it was thought to be limited in its application according to what choices are deemed to be legitimate.

Legitimate expectations

Reciprocity

Participants expressed the view that contextual factors are in constant play, and to a great extent determine the ability of HCPs to fulfil their duty to care. Just as there was a consistent thread of discussion throughout the day as to what constitutes a legitimate limit, participants kept returning to the question of what constitutes those policies and/or procedures that would enable an HCP to fulfil his or her duty to care. Treating questions of the duty to care “in isolation”, said one participant and echoed by others, was “too hard to answer.”

For this reason, limits to the duty to care do not emerge as, or are not expected to be within the limits of, their own capacities, but rather, they were viewed as depending upon institutional and societal supports, especially given the “increased demands and higher risk of exposure” that HCPs face during a pandemic. One participant said that, “clearly, society has a huge role to play.” Thus, according to participants, the duty to care implies a reciprocal duty to protect: “We have to do something as a society; do everything we can to protect [HCPs].” The negative consequences of not doing so were significant: “If support is not provided, the whole system will collapse.”

According to participants, the duty to protect HCPs as a requirement of the duty to care thus entails two forms of obligations: the first is to provide adequate personal protective equipment, which was thought to be an “imperative.” Referring to practitioners’ need for protection, a participant stated that: “You have to be provided with a safe working environment—whatever it takes.” Many invoked the “right to a safe working environment,” coupled with the “right to refuse dangerous work” without the “proper equipment.” Some participants suggested that the extension of support systems for HCPs during a pandemic, e.g. child care and increased compensation, could support them in resolving many of their dilemmas. Many agreed with the observation that: “She’s [physician] not going to be any good at work if she’s [physician] dealing with a crisis at home.” Although for some participants, the responsibility of provision fell on the institution in which a practitioner worked, while for others it fell on government, most wondered: “Who is supposed to provide [protective equipment]?” “Who guarantees that everything is adequate?” “Who do you trust [to act] in the best interests of the HCP?”

The second obligation is to give priority to HCPs and their families to both prophylaxis and treatment. One participant asserted, without giving further explanation: “They have to have priority; it is an obligation of society to prioritize them.” Doing so seemed to be motivated by three very different considerations. For some participants, it was understood as a value in and of itself; that is, it is “the right thing to do.” Others, however, instrumentalised it as being an incentive for HCPs to provide care: “If she’s protected, she can go to work.” Yet others appealed to an HCPs social value, i.e. his or her social usefulness in a pandemic, thus invoking another instrumental, perhaps more controversial, argument to justify giving priority access to HCPs: “[They] are in a position that is beneficial during a pandemic.”

Enforcement and planning

That HCPs can appeal to personal choice, have a duty constitutive of legitimate limits, and are owed a reciprocal duty of protection was not posited without debate. There was an animated discussion concerning the question of enforcement. Participants explored whether policies designed to promote the provision of care should be enforced, and by whom. Throughout deliberations, most continued to wonder who ought to have the authority to make these decisions, leaving open the repeated question, “at what level do you have authority?” The vast majority, however, concluded that there should not be consequences for not fulfilling a duty. Of the reasons offered in support of that view, the most prominent were that: coercion is “undemocratic”, and thus “unacceptable”; HCPs would be “no good” if they were coerced to work; imposing punitive measures, such as back-to-work legislation, which was thought to be “ridiculous”, would have “too many implications for the profession” in that “it would deter people from going into that line of work” or urge them to “leave the medical profession” altogether. Given these reasons, the most important policy initiative was thought to be one that “creates a supportive environment for personal decision-making,” that respects

“individualised circumstantial limits,” while creating incentives and putting in place supports for HCPs.

Throughout the deliberations, many began to see what was originally understood to be a question of enforcement as one of accountability conferred on HCPs by virtue of their duty to care. Thus the discussion about enforcement, whether or not one has a legitimate reason, led to a discussion about the need to establish what constitutes a legitimate reason in the first place. A participant, who wondered whether there were “rules” that could be followed, decided that “it all boils down to those rules; having rules [during a crisis] is key.” While there was some consideration to the fact that turning to legislation opened up a “can of worms”, there was great emphasis placed on the need to have “really clear guidelines” that are “thought through ahead of time,” otherwise “people are going to be a long time picking up the pieces.” For those who thought that there should be consequences, it was still too difficult, if not impossible, to enforce it. As one participant said, “I’m not saying there shouldn’t be consequences [but] you just can’t enforce it.” In the same vein, another said simply: “That’s the dilemma.”

Finally, there was consensus that the “best way to proceed,” perhaps “the only way” to resolve this dilemma, was through both “collaborative decision-making” (i.e. committees) and “public engagement” (“feed up input from the general level”) in a spirit of “transparency and openness” and “consistent, accessible, dynamic” communication. Just like participants thought that there would be dire consequences (“the system would collapse”) if there were no supports for HCPs, the consequences of not having “proactive safeguards and protocols” were just so: “Social structures will breakdown.”

Discussion

An important finding of this study is that participants viewed the duty to care as a complex duty that extends beyond individual obligations, reflecting the interplay of considerations that generate and limit it. While it was acknowledged as being a personal choice, personal choice was not an endpoint—i.e. first there are legitimate limits, then there is personal choice on which one can fall. Rather, it was a starting point—i.e. first there is personal choice, which is then bound by legitimate limits. On that basis, it was thought to be wholly legitimate to expect HCPs to care during pandemics despite the inherent risk to—and in virtue of their presumed consent to risk by—HCPs. A crucial caveat here is that this expectation applies to those who have taken an oath to care, i.e. physicians. That being said, even for physicians, like other practitioners, there was a greater expectation (than that of providing care despite risk): that of reciprocity, and in particular, the reciprocal duty to protect.

In this vein, participants suggested that we might derive obligations to care by appealing to reciprocity in two ways: 1) that legitimate limits are set (at least in part) by the availability of the necessary resources and supports for HCPs (e.g. adequate personal protective equipment); and, of great significance, 2) that HCPs ought to be given priority access to *both* prophylaxis and treatment based on what they understood to be the social value (or utility) of HCPs. This finding has important implications for policy-makers and pandemic planners: while it is now widely accepted that HCPs are deemed a priority group for prophylaxis (Gardam et al., 2007; Moghadas, 2010; World Health Organization, 2008), prioritizing access to treatment based on social value, at least for HCPs, has been equally widely debated or altogether discounted in policy circles. That aside, the point here is that participants viewed the duty to care as being located within a broader context that determines HCPs’ ability to care.

That the duty to care was viewed as such is an interesting finding that straddles both the literature emphasizing the broader

context as a necessary source of support for fulfilling one's duty to care and the policy trend that continues to appeal to personal choice. Indeed, our findings are consistent with recent scholarship that asserts that contextual considerations ought to be incorporated into parameters defining duties and obligations. For example, Bensimon et al. (2007) argue that we ought to transcend the view that the duty to care is both derived and realized entirely from individual obligations, instead seeking to understand how it is defined and operates within a broader context. In contrast, however, Civaner and Arda (2008) consider whether the duty to care might be circumscribed by contextual constraints. In other words, while Civaner and Arda view the wider context as a potential source of constraint, Bensimon and colleagues view it, as did participants from the current study, as a catalyst to provide the conditions and resources necessary for HCPs to satisfy their duty.

On a policy front, the renewed focus by regulatory bodies to define—or, at the very least, to explicitly recognize the need to address—the duty to care as a critical element of practice in disaster situations is a promising development (Canadian Medical Association, 2008; College of Nurses of Ontario, 2009; College of Physicians and Surgeons of Nova Scotia, 2009). Yet, while some have proposed that the standard of care ought to be altered during a disaster or public health emergency (Agency for Healthcare Research and Quality, 2005; Institute of Medicine, 2009), others have countered that it is “unnecessary” or “unwise” to do so because “current [American] law already protects practitioners from being held to standards of conduct that are not reasonable under the circumstances, including severe constraints prevalent in disasters” (American Bar Association, 2011). In other words, it is argued that the same legal duty to care applies in *all* circumstances and, thus, ought not be redefined for contexts of contagion or crisis.

To date, few policies have been established to ease navigation during a pandemic. In particular, policies determining what constitute a legitimate reason to not provide care and what the expectations are—or whether there should even be expectations—have been lacking. This is largely because no regulatory body has transcended the conventional view that the decision to care is a personal choice. Although this last point is consistent with our findings that personal choice is fundamental to the duty to care, it falls far short of taking account of the more fundamental finding that contextual considerations are an essential part of how we ought to understand the duty to care, which was largely favoured by participants. This finding brings out the potential tensions between expectations emerging out of notions of minimally decent professionalism (Clark, 2005b) and appeals to personal choice.

Continuing to appeal to personal choice is surely problematic in light of the numerous empirical studies showing that the duty to care is either weakly conceptualized or poorly understood in practice. For instance, one study concluded that only a modest majority of HCPs recognize the obligation to treat patients during pandemics (Ehrenstein et al., 2006). Another study found that absenteeism may be as high as 85% at any point during a pandemic, with potential absence particularly concentrated amongst nursing and ancillary workers (Damery et al., 2009). While little data to our knowledge exist reporting absenteeism rates during recent communicable disease outbreaks, the Pan American Health Organization (2009) has remarked that absenteeism among health care workers was as high as 30% in some cases during the 2009–2010 H1N1 pandemic. Similarly, the U.S. Department of Health and Human Services (2009) found that, in some regions of Argentina, as many as 40% of health care workers did not go to work during the peak of the pandemic and, in New Zealand, hospital staff absenteeism created temporary stresses on

hospitals. Yet another study found that one-fifth of its participants either lacked adequate knowledge of the occupational risks when they chose the medical profession or were not sufficiently informed of these risks during their faculty education and training (Civaner & Arda, 2008).

Further investigation can no doubt elucidate this gap between policy and practice and, more fundamentally, give us clarity on what the duty to care is or ought to be. Through this study we are beginning to see the conception of a duty to care that is constitutive of contextual and extrinsic considerations—that is, it is a duty that can only be satisfied when it is placed in its broader context, while the decision to care is not, and ought never to be, mandated. This push and pull in the data between a duty to care that is either extrinsic or intrinsic, or both, mirrors the ambivalence in public policy and regulatory discussions as to whether the duty to care is a matter of choice or whether there ought to be firm expectations and a concomitant expectation of reciprocity. This push and pull reinforces the reluctance to mandate the duty to care, while recognizing that it should be treated, and ought to be resolved, within a broader institutional and societal context, not at the individual level.

What is more, it is striking to see that the complex conceptual terrain covered by study participants is analogous to the global consultations on the duty to care (Singer et al., 2003), which points to the ambiguity in and complexity of considerations of the duty to care, while leaving it unresolved.

We are thus left with a number of conceptual and empirical questions that should prove fertile ground for scholarship and policy-making. One such question is regarding the interaction between reciprocity and duty to care. What does it mean to say that reciprocal support and protections are necessary conditions for a duty to care? Does the absence of these reciprocal factors neutralize the duty to care altogether or does it simply limit the scope of a duty to care to within the limits of one's own efforts? Moreover, much of the duty to care literature discusses the relationship between HCPs' duty and the risks they assume by entering the profession. Indeed, some may suggest that a strict duty to care exists for HCPs during infectious disease outbreaks as these risks are simply part of the job and were assumed by the HCP when he or she entered the profession. However, what is unclear is exactly what risks are assumed by HCPs in their respective professions and clinical responsibilities, and, for trainees, what and how such risks are described. Such questions are important to explore, as answers to these questions could reveal whether or not HCPs are being adequately informed of the risks that may exist in their profession, and what the limits to their duty might be in relation to these risks. Engaging trainees entering these professions would provide great insight into this issue.

This leads to a potential limitation of our study, which is that, while our scenario probed discussion of the duty to care by asking participants to consider a situation involving two physicians, participants expanded the discussion of the duty to care to include health care practitioners more generally. While some distinctions were made with regard to the particular obligations of specific types of health care practitioners (such as physicians), this study did not explicitly explore the distinct obligations that different health care practitioners may have.

We recognize that the views expressed by study participants may or may not be generalizable and that study participation was unevenly distributed across Canada, while there may be participant selection bias. However, this is consistent with standards of purposive sampling in qualitative research, which aims to evaluate the theoretical representativeness of participants by describing the range of views, rather than quantitative or demographic representativeness.

Conclusion

This study sought to describe public views on HCPs' duty to care during disasters. Our findings show that deliberation generates progressively nuanced and sophisticated views, as evidenced by the way in which participants appreciated and struggled with the complexity of considerations embedded in the duty to care. Even as they vacillated between at times contradictory and conflicting views, virtually every participant moved away from categorical notions of the duty to care towards more equivocal and often normative views throughout the course of the day. Our analysis contributes a better understanding of the constitutive nature of the duty to care, defined in part by taking account of public views. Public views allow us to reflect upon how professional obligations align with public opinion, perhaps contributing to something similar to Rawls's (1999) process of reflective equilibrium to negotiate decisions. This broadened understanding can further inform the articulation of acceptable norms of the duty to care and policy development efforts. What is more, it illustrates the urgent need for policy-makers and regulators to get clarity on obligations, responsibilities, and accountability in the application of HCPs' duty to care during times of universal vulnerability.

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Appendix A. Supplementary data

Supplementary data associated with this article can be found, in the online version, at <http://dx.doi.org/10.1016/j.socscimed.2012.09.021>.

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