DISTRIBUTIVE JUSTICE AND THE HARM TO MEDICAL PROFESSIONALS FIGHTING EPIDEMICS

Andreas Albertsen (Department of Political Science, Aarhus University) and Jens Damgaard Thaysen (Department of Learning and Philosophy, Centre for Applied Philosophy, Aalborg University)

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Abstract

The exposure of doctors, nurses and other medical professionals to risks in the context of epidemics is significant. While traditional medical ethics offers the thought that these dangers may limit the extent to which a duty to care is applicable in such situations, it has less to say about what we might owe to medical professionals who are disadvantaged in these contexts. Luck egalitarianism, a responsibility-sensitive theory of distributive justice, appears to fare particularly bad in that regard. If we want to maintain that the medical professionals are responsible for their decisions to help, cure and care for the vulnerable, luck egalitarianism seems to imply that their claim of justice to medical attention in case of infection is weak or non-existent. The article demonstrates how a recent

interpretation of luck egalitarianism offers a solution to this problem. Redefining luck egalitarianism as concerned with responsibility for creating disadvantages, rather than for incurring disadvantage as such, makes it possible to maintain that medical professionals are responsible for their choices, and that those infected because of their choice to help fight epidemics have a full claim of justice to medical attention.

Introduction

In September 2014, Ian Crozier, an American doctor, contracted Ebola while treating Ebola-patients in Sierra Leone during the epidemic sweeping through West Africa.[1] Unlike his patients, Crozier could have avoided exposing himself to the risk of infection by staying in the United States. A preliminary report on the West African Ebola outbreak suggests that medical professionals were significantly more likely to contract Ebola than the general adult population. The overexposure ranges from 21 times more likely for doctors, to 32 times more likely for nurses.[2] While Crozier could not have known these particulars, he must have been aware that treating epidemic diseases in countries with low institutional capacity exposes one to a non-trivial risk of ending up among the infected. He chose to push through anyway. It is thus reasonable to suppose that Crozier was genuinely responsible for exposing himself to the risk, which led to his infection with the Ebola virus. Existing discussions often argue that circumstances of high risk may lessen the extent to which medical professionals have a duty to care. However, they say little about what we owe to those who, despite such circumstance, choose to do so and get injured in the process.[3–5] Did Crozier have a claim of justice to the scarce medical resources necessary to treat his infection just as strong as that of his patients, (most of) whom were not responsible for exposing themselves to the risk of infection? A negative answer to this question seems untenable. Yet *prima facie* luck egalitarianism must make this verdict.

Luck egalitarianism is a prominent theory of distributive justice which has recently been applied to distributions of health(care).[6–10] According to luck egalitarianism, distributions are just if, and only if, they reflect people's exercise of responsibility.[11–15] As outlined above, it seems difficult to deny that Crozier's infection was a reasonably foreseeable result of his exercise of responsibility, i.e., his choice to travel from the United States to Sierra Leone in order to treat Ebola-patients. The example of Ian Crozier provides a particularly clear example of something that

is generally true of medical professionals: Most doctors and nurses have become medical professionals through a free exercise of responsibility, and they are, in general, earning their living in a risky profession.[16,17] When the risks of being a medical professional materialize, then luck egalitarianism seems to imply that doctors and nurses, who contract the infectious disease they are treating, have a weaker claim (of justice) to medical attention than the typical patient. Instead, it is on par with the claim of others who require medical attention as a reasonably foreseeable result of their risky choices. To put it bluntly, luck egalitarianism seems unable to distinguish between the Ebola infection of Ian Crozier and the injury of a well-educated alpine skier, who is injured in a way deemed equally serious and as a reasonably foreseeable consequence of the choice to go skiing. All that matters for the purposes of luck egalitarianism is that both health exercises of responsibility.

This article discusses the requirements of justice when medical professionals require medical attention as a reasonably foreseeable consequence of their, fully voluntary, choice to fight epidemics by treating the infected and attempting to prevent the spread of disease, and what this should make us conclude about the prospects of luck egalitarianism as a theory of justice in health. This is done by discussing the relative merits of three possible conclusions. First, that the *prima facie* verdict of luck egalitarianism is the right one; second, that luck egalitarianism should be abandoned (at least as theory of justice in health) in the light of the verdict it yields when medical professionals require medical attention as a reasonably foreseeable consequence of their choice to fight epidemics; and, third, that luck egalitarianism need not yield the verdict which it seems *prima facie* committed to making.

Why we should treat infected medical professionals differently than injured skiers

The *prima facie* luck egalitarian verdict that medical professionals who contract an epidemic disease as a reasonably foreseeable result of their choice to treat the infected have a weak, or non-existent, claim of justice to medical attention seems the least appealing of the three options at hand. To understand why, let us briefly explore some differences between the Ebola struck medical professional and the seriously injured alpine skier.

One important difference is that the medical professional contracted Ebola due to a morally good choice, that of treating Ebola-patients, whereas the alpine skier was seriously injured due to a morally neutral choice, that of alpine skiing. Second, the two choices differ in how they affect the overall amount of disadvantage. Disadvantage refers to a loss of whatever one holds to be the ultimate currency of justice, thus, the argument is neutral between views holding this to be welfare, resources, capabilities etc. Regardless of what one holds to be the ultimate currency of justice, medical professionals who contract the epidemic disease they are treating are disadvantaged because of a choice to remove or prevent disadvantage which others would otherwise have suffered. When medical professionals treat those infected by epidemic disease, they are actively attempting to remove the disadvantage suffered by their patients. When medical professionals attempt to contain the spread of the epidemic, they are actively attempting to prevent a potentially great number of others from suffering the disadvantage of infection at all. Medical professionals often cannot treat the infected without exposing themselves to an increased risk of contracting the disease. Medical professionals who contract the epidemic disease they are treating are thus normally not merely contracting the disease *while* treating the infected, but *because* they treat the infected. Even on the most conservative assumptions, the actions of such medical professionals do not increase the amount of disadvantage in the world. It is likely that such actions even decrease the amount of disadvantage, but we need only assume that they do not increase it. Conversely, the actions of the injured alpine skier increase the amount of disadvantage. No one is better off because of his or her

choice to ski. In light of these differences, it is also clear that we would have less reason to dissuade the medical professional than the alpine skier. Caring for those who need it the most, even when doing so poses some risk to oneself, is hardly the kind of choice which it seems fitting to deter people from. The highlighted differences also seem to feature prominently in Anderson's critique of luck egalitarianism for abandoning the vulnerable caretakers, who have less than they could have had due to their choices of caring for others.[18]

One could attempt to argue that the verdict is acceptable after all because it is compatible with Crozier and other medical professionals having *some claim* to treatment on grounds unrelated to justice (i.e. charity). However, this reply is unsatisfactory. *Ceteris paribus* those with a justice-related claim to treatment do not have a weaker charity-related claim to treatment. Therefore, this line of argument does not avoid the implication that the relevant medical professionals have *a weaker claim* than their typical patients, and that when there is not resources enough to treat everybody the disadvantaged medical professionals should be given lower priority than those whose disadvantage do not reflect their exercises of responsibility. There are, of course, circumstances under which it would actually be just to give lower priority to the medical needs of medical professionals who contract the epidemic disease they are treating. Namely, when the disease is contracted because of risk-taking, which is unrelated or unnecessary to the treatment of the infected people**.** However, the typical case is hardly that of the medical professional who is infected because of a failure to take the reasonable precautions, but rather that of the medical professional who is infected despite taking every possible precaution. If luck egalitarianism cannot explain why medical professionals who contract an epidemic disease as a reasonably foreseeable result of their choice to treat the infected people have a claim of justice to medical attention equal to that of their patients, then luck egalitarianism's appeal when applied to issues of health and health care is severely undermined. Indeed, insofar as distributions of health and health care are matters of

distributive justice, the *prima facie* verdict threatens the appeal of luck egalitarianism as a theory of distributive justice in general.

Why we should not abandon luck egalitarianism

Our intuitions favor the verdict that medical professionals who contract the epidemic disease they are treating have a full claim of justice to medical attention. Luck egalitarianism seems to yield the opposite verdict. This section offers some reasons to hesitate before concluding that this should make us abandon luck egalitarianism. Though it remains controversial [19–31], many find the application of luck egalitarianism to the distribution of healthcare attractive, because it allows the distribution of scarce healthcare resources to be influenced by the degree to which those in need are responsible for their own predicament. Take the example of organ transplants. In the face of a severe shortage of organs available for transplant, it has a certain intuitive plausibility that lower priority should be given to those who are in need of a transplant because of their own exercises of responsibility. Furthermore, luck egalitarianism provides an admirably clear-cut explanation of why many actual existing health inequalities are unjust, namely, that these inequalities reflect differences in social circumstances, rather than differences in exercises of responsibility. [32,33]

Moreover, rejecting the relevance of responsibility in the assessment of the justice of health distributions is not the simple solution it appears to be. Many approaches that reject the relevance of responsibility, including the main rivals of luck egalitarianism in health, face a problem structurally similar to that facing luck egalitarianism. If responsibility is irrelevant, then we will have no problem explaining why medical professionals who contract the epidemic disease they are treating have a full claim of justice to medical attention. However, we will remain unable to distinguish between the medical needs of these medical professionals, and those of some reckless alpine skier, who will also have a full claim of justice to medical attention if the relevance of responsibility is abandoned. This indicates that rejecting the relevance of responsibility fails to

solve the problem at hand fully. Admittedly, a full discussion of the plausibility of luck egalitarianism in health is not possible here. All we hope to establish in this section is that the merits of luck egalitarianism in health warrant investigating whether luck egalitarianism can be adjusted to handle the case at hand, before abandoning it due to its *prima facie* verdict that the disadvantages suffered by medical professionals, who contract the epidemic disease they are treating, are just.

How luck egalitarianism can distinguish between heroes and fools

Is there any hope of adjusting or interpreting luck egalitarianism in such a way that it is able to explain why it is unjust when medical professionals are disadvantaged as a reasonably foreseeable consequence of their choice to treat those with infectious diseases, without abandoning the core commitment to responsibility-sensitivity? This section briefly considers three strategies for reconciling the intuition that such disadvantages are unjust with a commitment to responsibility-sensitivity, before presenting our favored response.

The first strategy is to argue that luck egalitarians can treat medical professionals who travel to an epidemic-stricken country in order to treat the infected people and alpine skiers as equally responsible for the consequences of their choices by requiring both to insure themselves. This would dodge the whole issue by giving medical professionals who contract the disease a claim of justice to medical resources in virtue of their insurance. Luck egalitarians could then take into account the goodness and efficiency of treating epidemics by paying the insurance premium of medical professionals but not that of alpine skiers. It is, however, unclear how paying the insurance premium of the medical professional but not of the skier is justified on luck egalitarian grounds given their equal responsibility. Since luck egalitarianism purports to be a complete theory of

distributive justice, it is therefore also unclear how luck egalitarians could hold the medical professional to have a claim of justice to having the costs of his insurance covered, though he might have some other kind of claim.

The second strategy, inspired by Arneson, is to argue that medical professionals are not responsible for the choice to fight epidemics because they are merely performing their duty, and performing one's duty is not an exercise of responsibility in the relevant sense.[34] This would make the disadvantages suffered by these medical professionals a standard luck egalitarian case of injustice**.** One problem with this strategy is that medical professionals who choose to fight epidemics knowing that this choice exposes them to an increased risk of infection does not seem to be *merely* performing their duty, but to be going beyond it.[3] They are doing what is supererogatory, rather than morally obligatory. While Crozier should be praised for going to Sierra Leone, those who chose to stay at home were hardly in breach of their duties. Moreover, we want to praise medical professionals who fight epidemics, but this seems appropriate only if they are, in fact, responsible for their choice to fight the epidemic.

A third strategy is to argue that medical professionals fighting epidemics are not responsible for the disadvantages they incur, because these medical professionals lack responsibility for the circumstances in which they can only help others at some risk to themselves (that is, the fact that there is an epidemic). This possibility is suggested by Temkin in a more general context.[35] The problem with this strategy is that it only explains why medical professionals who contract the epidemic disease they are treating are not responsible for being worse off than those medical professionals who, for some reason, lacked the opportunity to treat the infected people. It does not explain why the infected medical professional is not responsible for being worse off than those medical professionals who had the opportunity but chose not to run the risk of infection.

While there is more to say about the luck egalitarian suggestions discussed above, doing so is not possible within the confines of this article. The suggestions all face some serious shortcomings when applied to the case of medical professionals who contract the epidemic disease they have chosen to fight. A last luck egalitarian strategy seems more promising. In a recent paper, Thaysen and Albertsen have argued that luck egalitarianism should only be concerned with responsibility for *creating* disadvantages.[36] A person is responsible for *creating* a disadvantage, when he or she is responsible for acting in such a way that *someone*, rather than no one, will be disadvantaged. It is possible to be responsible for *incurring* a disadvantage, which one is not responsible for *creating*. This is the case when persons are responsible for acting in such a way that they suffer a disadvantage which would have been suffered by someone else if not for that exact same exercise of responsibility. The disadvantage incurred by medical professionals who contract the epidemic disease they have chosen to fight is a paradigmatic example of a disadvantage which people are responsible for *incurring* but not for creating. If the medical professionals who treat the infected people and who take measures to contain the spread of the contagious disease had not exercised their responsibility in this way, which it was reasonably foreseeable would expose them to an increased risk of being infected, then it would be expected that someone else, or even many others, would have contracted the disease instead, because there had been fewer to treat the infected and to prevent the disease from spreading further. While medical professionals who contract the epidemic disease they are fighting are thus responsible for incurring this disadvantage, they are not responsible for *creating* it. Although these claims are empirical, the presence of medical professionals during epidemics would be a liability, rather than an asset, unless they are true. We feel confident that this is not the case. The claim that infected medical professionals are generally not responsible for *creating* their disadvantage is conservative indeed, in all probability they are responsible for preventing disadvantage far in excess of what they incur. By contrast, the severely

injured alpine skier is responsible for creating his or her disadvantage, since had the person not gone skiing, then it is not true that an additional other person would have sustained the injuries. It is logically possible that a medical professional's choice to fight an epidemic might cause them to be infected without preventing others from being infected (although this might never actually happen). This could for instance be because a sufficient number of other medical professionals are already present and there is no need for an extra medical professional. In that event, the disadvantage incurred by the infected medical professional is created by his or her choice to fight epidemics. This person is, however, only *responsible* for creating this disadvantage if it was reasonably foreseeable that an extra medical professional was not needed. If this was not foreseeable, then the medical professional lacks responsibility for creating the disadvantage incurred and is entitled to compensation on luck egalitarian grounds. If it was foreseeable, on the other hand, the medical professional seems no less foolish than the reckless skier, and treating them similarly seems unproblematic. This also highlights why well-intentioned, but misguided, non-professionals who travel to an epidemic-stricken country in order to help, but lack any relevant skills, would be responsible for creating the disadvantage they incurred, if they were infected.

Thus, the version of luck egalitarianism developed by Thaysen and Albertsen is able to explain why it is unjust when medical professionals are disadvantaged as a reasonably foreseeable consequence of their choice to fight epidemics. It explains why medical professionals infected in such a context have a full claim of justice to medical attention. It does so while maintaining that distributive justice in general, including justice in health, is responsibility-sensitive. However, it is sensitive only to responsibility for creating disadvantage, while being insensitive to responsibility for distributing disadvantage to oneself. Medical professionals who contract an epidemic disease as a reasonably foreseeable consequence of their choice to treat the infected lack responsibility for creating the disadvantage they suffer. This is what makes the

disadvantage unjust. Note that this view is compatible with praising such medical professionals, since it is not denied that they are responsible for distributing the disadvantage to themselves by risking infection in order to prevent others from being infected. This is important, since such a choice is indeed heroic, and we are right to praise medical professionals for making it. Note also that this adjustment of luck egalitarianism retains the features that make it an appealing theory of justice in health. The paradigmatic cases where it seems sensible to give lower priority to those responsible for their health problems, like that of people with lifestyle diseases, all involve people who are responsible for creating the disadvantage they suffer. If the injured alpine skier had not gone skiing, there would have been one less person with her injuries. If Ian Crozier had not gone to Sierra Leone to help fight the Ebola virus in 2014, then there would not have been one less person infected with the Ebola virus. Because even if Ian Crozier would not himself have contracted the Ebola virus had he not gone to Sierra Leone, his choice to do so helped prevent others from contracting the disease. This is why the most plausible version of a responsibility-sensitive theory of distributive justice must be able to explain why he – and other medical professionals like him – has a full claim of justice to medical attention.

Conclusion

Explaining why medical professionals who contract the epidemic disease they are treating have a full claim of justice to medical attention seems a hard case for a responsibility-sensitive theory of distributive justice such as luck egalitarianism. One possible reaction, however, is to introduce a distinction between whether people have created a disadvantage or merely incurred an already existing disadvantage. This distinction allows luck egalitarianism to maintain its responsibility-sensitive core, while explaining why medical professionals infected while fighting epidemics have a full claim of justice to medical attention. This admittedly only works if a version of luck

egalitarianism solely concerned with the responsibility for creating disadvantage yields plausible answers in general. While we lack the space to provide a general defense of its plausibility here, Thaysen and Albertsen has defended the plausibility of this version of luck egalitarianism across a number of different cases.[36] Important questions no doubt remain. The fact that this version of luck egalitarianism explains the injustice of disadvantages incurred by medical professionals because of choices to fight epidemics is, however, a point in its favor. Given the lack of other convincing luck egalitarian explanations for this, it seems that if this version of luck egalitarianism fails, the case of medical professionals disadvantaged by their choice to fight epidemics undercuts the plausibility of luck egalitarianism in health. That too would be a quite interesting conclusion.

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