FEATURE

PATIENTS' CARE AND PUBLIC HEALTH: ARE THE RULES THE SAME?

by Bernard M. Dickens

The sudden appearance of SARS (severe acute respiratory syndrome) in the world, particularly since mid-March in Canada with a concentration in Toronto, has raised the question of legal responses to viral infection affecting communities. Healthcare professionals and healthcare systems are equipped to deal with patients' health risks, but SARS also presents risks to the caring professionals and the healthcare system itself.

Health professionals have duties to care for the sick, hospitals have duties to admit them and patients have rights to appropriate management. However, these duties and rights can conflict with health professionals' responsibility not to spread infection to patients, colleagues or their own family members; hospitals' duties to provide employees with a safe work environment; and exposed persons' duties of self-discipline to prevent further infection of others.

As a result, we find health professionals questioning whether they must treat patients suspected to have SARS, and hospitals isolating suspect patients, refusing to admit non-emergency patients in need of other treatment, and suspending training of medical and nursing students. Exposed healthcare employees with no symptoms have been ordered to take sick leave, even when not entitled to full pay while absent. Health officials have threatened involuntary detention of patients refusing or failing to comply with preventative measures, by quarantine.

These responses, which are not irrational, show contrasts between the legal system's method of addressing patients' rights to care and the operation of the public health service. Patients are treated primarily through legal principles of clinical or individual care, but the public health service functions at a communal or collective level. The legal rules applicable to each are not always the same.

Common to both clinical care and the public health system are legal rights of sick and suspect persons to medical diagnosis and indicated treatment. They must have reasonable access to medically necessary care, although this may not be at a hospital of their choice, or by their usual healthcare providers. Similarly, healthcare providers' general rights to decide whether to treat those who seek their aid are subject to terms of employment and duties of non-discrimination, for instance on grounds of applicants' ethnic origin, or physical disability such as hepatitis, HIV/AIDS or SARS.

Unlike patients that are generally free to leave hospital even against medical advice, however, those who pose a risk of infection to others outside the hospital setting are liable to involuntary detention. The *Canadian Charter of Rights and Freedoms* governs whether they can be treated against their will; but whether or not they can be involuntarily treated, they can be involuntarily detained under regulations that give effect to public health legislation. The inclusion of SARS in such regulations empowers public health officers to enforce detention while individuals pose a danger to the public.

Public health legislation is applied through officials who stress their healthcare commitment, but its principles are similar to those that empower police officers. Like police, public health officials can detain on reasonable suspicion, interrogate suspects about their recent contacts and movements, and warn those who may have been exposed to risk, including individuals and members of communities. Health officers can obtain police assistance to enter premises to find and detain those suspected of presenting a risk of infecting others.

Patients' rights to confidentiality that must be respected in clinical settings must be preserved to the maximum extent in public health settings. People who learn that they have been in contact with persons who may have exposed them to infection will not be given such persons' names or identities. However, for purposes of public health research and individual surveillance, individual identities of suspects may be shared among public health and healthcare personnel. Public protection is not subject to individual veto. Within hospitals, employees may have to be able to identify patients who pose risk of infection to other patients and to themselves.

Anonymity should be preserved to the greatest possible extent. Tissue samples for laboratory testing will be coded, not named, and employees will maintain precautions against infection by all patients, whether or not diagnosed as infectious. Appropriate masking and hand-washing may become routine, for instance, in all cases. Where close face-to-face contact is involved, however, as in intubating and extubating patients with respiratory difficulties, healthcare workers need to know which patients pose particular risks.

(continued on page 72)

RNs were trained elsewhere, as well as 30 percent of Alberta's. By contrast, 96 percent of Quebec's RNs and 93 percent of Newfoundland and Labrador's were trained in their own provinces.

The past four years have seen a major shift from casual to full-time work. The number of RNs working full-time reached a five-year high of 54.1 percent in 2002, compared to 49.1 percent in 1998. During the same period, casual employment dropped by one-third, to 11.8 percent in 2002 from 18.6 percent in 1998. Part-time employment increased only marginally, from 32.2 percent in 1998 to 33.8 percent in 2002.

Health ministers meet

The federal, provincial and territorial ministers of health agreed to continue to make public health a top priority by improving public health infrastructure and increasing institutional, provincial, territorial and federal capacity that builds on current strengths and successes across the country. The decision was reached at the conference of the federal, provincial and territorial ministers of health in Halifax, Nova Scotia.

The ministers agreed to collaborate on the development of an enhanced public health system and have asked officials to return later this fall with an update that would include progress on:

- clarification of roles and responsibilities for preventing and responding effectively to public health threats, respecting federal, provincial and territorial jurisdictions;
- creation of a national network of centres of public health science;
- strengthened public health human resources, including the need for more robust regional and national public health emergency response capacity; and
- enhanced national surveillance and information infrastructure.

Health ministers agreed to use the next seven weeks to expedite work on the Health Council. Ministers will recommend a chair, suggest non-governmental representatives and name government representatives. They will work to ensure that the Council has an appropriate mandate consistent with the 2003 First Ministers Agreement and is affordable and non-bureaucratic, and will make recommendations to their respective first ministers regarding these issues.

Newsworthy material should be submitted to Rashi Sharma at rsharma@longwoods.com.

Patients' care and public health

(continued from page 70)

When an anti-SARS vaccine or other preventive means first becomes available, an inversion of a primary medical ethic may be legally justifiable. The first principle of the Canadian Medical Association's Code of Ethics is that the ethical physician will "consider first the well-being of the patient." In a contest between interests of patients and doctors, patients' interests have priority. At a public health level, however, priority in allocation of a new, scarce preventive healthcare resource may justifiably be given to health professionals.

As personnel whose work exposes them to higher than usual risk of infection, on whom community members depend for safe, readily available necessary services, healthcare employees' claims to priority access to anti-SARS protection are justifiable, without discrimination against members of the general public.

Reprinted with permission.
Bernard Dickens, MHSc, is the Associate Director of the University of Toronto and International Bioethics. For more information, please contact Bernard Dickens at Bernard.Dickens@utoronto.ca

Twelve issues per year
A FOCUS Publication
260 Adelaide Street East, No. 8
Toronto, Ontario Canada M5A 1N1
Telephone: (416) 864-9667
Facsimile: (416) 368-6292
Email: cmartin@longwoods.com
Internet: www.longwoods.com
ISSN 1703-4396 Printed in Canada