Risk-taking and professional responsibility

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There are numerous occupations in which the worker is placed at higher risk of injury or disease than the average for the whole population. This excess risk can stem either from an increase in specific risk for some disease or injury or from a global increase in risk. Shop attendants are prone to varicose veins, fire-fighters commonly have serious accidents, soldiers may be killed or maimed in several different ways, schoolteachers are exposed to violent students, moral philosophers may be attacked (both verbally and physically) for their outrageous views and health care workers are exposed to infection and sometimes violence.

The usual assumption is that persons in some of these occupational groups have special obligations to expose themselves to risk, whereas those in other kinds of work have no such obligations. For example, doctors belong to a profession with special obligations whereas there is no similar profession for shop attendants. This is obviously unsatisfying as a serious answer to the question of how and why a person acquires occupational or professional responsibilities.

Here we discuss what obligations a person can have with regard to occupational risks, and the source of these obligations. This question has great social and practical importance because, both as individuals and as a society, we need groups of people who are obliged to expose themselves to risks of various kinds.

OBLIGATIONS AND CONTRACT

One way of developing an account of obligations with regard to occupational risks is through the moral and legal obligation to honour a contract. The argument could be made that if a person has entered into a contract with the fire department to be employed as a fire fighter then he or she has thereby accepted any and all risks accompanying this occupation. Later in the paper we will look into the dilemmas that arise if the risks accompanying a given occupation change for the worse, but initially we address the problems inherent in a contractual account of obligations in a stable risk environment.

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First, a person who signs a contract entailing obligatory exposure to risk must have some knowledge of the risks he or she will run and take account of them. The decision may be to disregard the known risks; the important thing is that workers understand the nature of the risks and take them into account.

Secondly, employment contracts usually only bind employees to perform their duties during the agreed working hours. There may be special clauses requiring the employees not to bring the company into disrepute by activities undertaken in their spare time, but employment contracts specifying positive obligations outside of the working hours are rare. However, we expect some persons (e.g. doctors) to discharge specific obligations (e.g. helping accident victims) even if they are off work, are on vacation, or are temporarily unemployed. This expectation cannot be justified or explained by the doctors' employment contracts, and must be explained in some other way.

Thirdly, the moral duty to keep to the terms of an employment contract is not usually seen as a very stringent duty. A person is not seen as a very bad person if he or she breaks the contract—for example, when something better comes along, or when they are unhappy with the job.

These three points indicate that, if some occupational groups are indeed obliged to expose themselves to risk, this obligation does not fit well with a contract model.

OBLIGATIONS AND PROFESSIONAL CODES

The traditional way to justify occupational obligations of risk exposure is through the concepts of a profession and of professional obligations.

The exact definition of a profession is something over which much ink has been spilt, but for our purposes it is sufficient to use a standard dictionary definition where a profession is defined as:

'. . . an occupation requiring advanced education and involving intellectual skills, as medicine, law, theology, engineering, teaching'[1].

It is usually assumed that professional status includes both privileges (exclusive rights to perform certain actions) and obligations. The obligations are often formalized in a professional code of ethics, which has usually been formulated by the profession without any outside

interference. This weakens the claim of a professional code to have moral force in the relation between society (or the individual person) and the profession, but it does not necessarily detract from the code's moral authority within the profession.

If we look at obligations to expose oneself to risk it is, however, even more problematic to base these on professional codes of ethics. First, the class of people to whom we attribute obligations to expose themselves to risk is not coextensive with the class of people who are members of recognized professions. There are many occupations where this obligation is implicit or explicit, but where no profession exists. Further, difficulties arise when we try to delimit the group of people who, through their professional status, have accepted and/or acquired certain professional obligations and when we try to individuate these obligations. These problems have a 'temporal', a 'spatial' and a 'systemic' aspect, as illustrated by three questions about the medical profession:

- When does a person become a member of the medical profession, and when does a person cease to be a member?
- Do all members of the medical profession have the same obligations to expose themselves to risk of, for instance, transmission of infectious diseases, or do specialists in infectious diseases have greater obligations than child psychiatrists?
- Does the obligation to expose oneself to certain forms of risk fall on the medical profession as a whole, and if so, how is this obligation further individuated to decide exactly who has the obligation toward a specific patient?

The first question has obvious legal answers, but these do not help with the ethical issue. The second author of this paper holds a full Danish licence to practise independently as a physician. This licence is not valid in the Democratic Republic of the Congo, and there would be no legal obligation (or right) to treat patients there. But would this remove the moral obligation to help people (and thus expose himself to considerable risk) if he was the only medically trained person present in a village during an outbreak of Ebola fever?

The second question is of interest because it casts doubt on the outward appearance of the medical profession as a uniform body. We know that the choice of specialty is not random. Doctors choose specialties that suit their personality, and at least some doctors working in clinical chemistry (for example) chose that path precisely to avoid contact with patients. Do they have the same obligations as all other doctors?

The third question brings us back to the grounding of professional obligations. If we reconceptualize professional obligations in a way that makes them fall on the whole profession and not only on certain individuals, we may perhaps be able to bring back a 'second-order contract', not between the individual doctor and his employer (or his patients), but between society and the medical profession. We have in mind here a contract that might state: 'in return for these specified privileges, we, the medical profession, promise to treat all people in need of care, irrespective of the risk it poses for ourselves'. But this idea of a second-order contract is, in the end, of little use because it does not specify exactly on whom the obligation towards a given patient falls.

FIRM OBLIGATIONS UNDER CHANGING CONDITIONS?

Further problems arise for both the contract account and the 'professional' account of occupational obligations if the risk environment is not stable. Different scenarios can be put forward incorporating both increased and decreased risks. The scenarios with decreased risks are interesting, but the questions they raise (e.g. should certain privileges be revoked when the risks that justified them disappear?) are outside the scope of the present paper.

In talking about obligations and increased risk three distinctions must be made—concerning the kind of risk, the foreseeability of the risk increase, and the magnitude of the risk increase. A person who chooses to become a shop attendant may knowingly accept the risk of varicose veins without thereby accepting other kinds of increased risk such as serious infectious disease during an epidemic or violence if the neighbourhood deteriorates. A person may in advance have accepted certain foreseeable increases in risk, without having accepted unforseeable increases. And a person may have accepted all risk increases of any magnitude. What if new risks emerge? Do old obligations remain binding? The existence of the old obligations has presumably created expectations of the delivery of services of certain kinds—expectations which become embedded in social structures. People expect the fire department to try to extinguish fires; and this expectation does not vanish the moment a fire out of control substantially raises the risk level to fire fighters.

HIV/AIDS

Parts of the argument above could be interpreted to yield the conclusion that physicians and other health care professionals are legitimately free not to treat people infected with human immunodeficiency virus (HIV). This is, however, a misinterpretation. The emergence of HIV/AIDS has added a factor to the risk environment of health care professionals, but it is not qualitatively different from previously known risks and the magnitude is small.

Singling out patients with HIV/AIDS would therefore not be justified, and this is perhaps best seen if we compare HIV/AIDS with influenza. Every 4–6 years we have a major 'flu epidemic because a new and qualitatively (antigenically) different strain of 'flu-virus has developed and few people have antibodies against it. During a 'flu epidemic health care professionals have a highly increased risk of being infected with an unpleasant disease; this risk is caused by something qualitatively new (i.e. the new strain of 'flu-virus); and the risk increase was unforseeable (at least with regard to the exact timing of the increase). Would it be right for health care professionals to renege on their obligations during a 'flu epidemic? Obviously not, and the reason is that, although each single 'flu epidemic constitutes a certain increase in risk, and although the infectious agent is qualitatively different from previously known agents, the general class of risk (exposure to infectious disease) is one of the oldest recognized as inherently connected with the occupation of a health care professional. Discovery of a new infectious agent does not create a sufficient fluctuation in the risk environment to allow the claim that old obligations are void.

Conditions may also change in other ways that could undermine an obligation to expose oneself to risk, even if such an obligation had not changed. This could be the case if the grounds for the acceptance of risk were no longer present. A soldier may have accepted a certain level of risk based on a desire to defend his or her country, but may justifiably not be willing to accept the same level of risk if the purpose of the mission is to prosecute an unjust war in a remote part of the world.

DIFFERENT SORTS OF OBLIGATIONS

Through the arguments presented above we have shown that there is no unitary way to ground obligations to assume a certain level of risk in the pursuit of a given occupation. But it is important to understand the reasons. Although the *levels* of risk may hold constant through different sorts of occupations, as indeed may the *nature* of the risk (to life, health, or whatever), what differs very often (but by no means always) between occupations are the *reasons* or *justifications* for undertaking the risk. What we need to examine therefore is not the differences and similarities between occupational groups, the ways in which they conduct themselves and the differences in their *self-image* so to speak, but rather the differences in the moral obligations that exist to do what they do.

If we ask why shop attendants should undergo increased risk of varicose veins, for example, the answer must be that this is a voluntarily assumed risk which the individual must justify to himself or herself if the rewards of the occupation are worth the risks. The shop attendant is obliged by contract to do his or her duties but most shop attendants are free to break their contacts at any time. If we turn from shop attendants to health professionals and ask why should health professionals run risks, for example of exposure to communicable diseases, in the course of their work, we get a rather different answer. It may be true that this is a voluntarily assumed risk which the individuals must justify to themselves if the rewards of the occupation are worth the risks required to gain those rewards; it may also be true that they are required by their contract of employment to do so, and further that they are required either expressly or implicitly by the rules or conventions of their profession or professional organizations. However, there is another, and many will think overriding, reason why they should undertake these risks. That reason, of course, is that the risks are necessary to protect others from injury, suffering or death. They are both necessary to protect others and they are in the public interest. An intermediate case might be that of schoolteachers exposed to violent students or moral philosophers exposed to attack for speaking the truth as they see it. Both the education of our children and the existence of independent analysts and critics (if that is what philosophers are) are in the public interest and arguably also necessary to protect the interests (if not the lives) of many citizens.

The existence of both a moral and a public-interest argument for people to run occupational risks does not mean that such risks should not be controlled and kept as small as possible. The precise meaning of such a claim, of course, is ambiguous since safety measures may be costly and the costs of reducing risks further by very small amounts may be disproportionate. However, in this paper we are assuming that there is agreement that the residual risk has been made as small as it can reasonably be.

THE RULE OF RESCUE

We have suggested that, while there is no unitary way to ground obligations to assume a certain level of risk in the pursuit of a given occupation, there may be a unitary way of identifying the obligation to run certain risks whatever the occupation. This common thread is a moral obligation, so that when we talk about the moral obligation to work we are not talking about anything like a 'work ethic' but rather we are interested in moral reasons that people have, and the moral obligations that exist, not only to do certain sorts of jobs but to run at least some of the risks that such jobs entail. We will start, though, with a type of moral obligation which is not related to occupations at all and see whether anything can be learned from this.

The rule of rescue provides an obvious model for exploring our assumptions and intuitions about moral

obligations to render aid. Most people accept that, when others stand in danger of their lives or of severe injury, pain or distress, there is a strong obligation to go to their assistance. This obligation is sufficiently powerful that it is not extinguished where a rescue involves some risk to rescuers. We tend to see this in terms of an obligation to prevent harm to others and those who do not discharge this obligation can be regarded as responsible for the harm that then accrues. This responsibility may, of course, be shared with others and the potential victims themselves and it may not involve legal responsibility in addition to the moral responsibility. However this may be, a crucial point is that there is a generally accepted obligation not to abandon those in need of rescue and an acceptance of the idea that people should be prepared to run some risks so as to affect the rescue. The risks that rescuers run must first be proportional to the harm to be prevented and second vary with the probability of successful rescue (the higher the probability, the greater the risks people should be prepared to run). It is impossible to quantify this in any exact way. However, we can give some rudimentary guide by confining ourselves to medical examples.

In the face of a major lethal epidemic it might be reasonable not only to expect people to present themselves for vaccination but even to require them to do so. Indeed most legal systems allow for the possibility of compulsory immunization. We can assume that immunization involves injection and therefore the invasion of bodily integrity, some pain and a small risk of lethal side effects. Even common childhood vaccinations such as measles, mumps, and rubella vaccine used in many European countries can have non-negligible side-effects[2,3]. Equally, most would accept that, in the face of a major catastrophe, there might be some obligation to give blood with the familiar attendant risks of pain, a local haematoma, and in rare cases fainting. Those who would deny these obligations would usually not do so on the grounds of the inherent risks, but because they see autonomy or bodily integrity as inviolable. But if that point of view is taken seriously, especially in the form that involves the inviolability of autonomy, most duties to others will immediately disappear. We will therefore disregard these arguments. Many would also feel an obligation, for example, to provide lifesaving bone marrow although the procedure is quite painful (comparable to being kicked in the thigh by a horse) and carries a very small risk of death for a healthy person—namely, that associated with general anaesthesia. The numbers of people who have no qualms about cosmetic surgery requiring general anaesthesia give some indication of how big a disincentive this is perceived to be. If bone marrow donation is perhaps at the upper limit of people's normal intuitions about what risks it is reasonable to run on behalf of others then clearly kidney donation, with 1 in 1600 surgical mortality in healthy donors, is beyond most people's intuitions about what is acceptable here.

A noteworthy feature of the rule of rescue is that it is one of the few commonly accepted moral duties that fall on everyone and can be claimed by anyone. Everyone has an obligation to participate in rescue at reasonable risk to themselves, irrespective of their occupation or contractual commitments.

PROFESSIONAL LACK OF RESPONSIBILITY

One of us has argued at some length that doctors do not have special obligations to treat patients[4]. Rather it is their special skills that uniquely qualify them to discharge an obligation that falls on all of us. Suppose we are all at the seaside, at a sheltered isolated bay and there are some two hundred people sunning themselves on the beach. A child gets into trouble somewhere out to sea and is in danger of drowning. Of the two hundred people on the beach, all hear the cries; one hundred are competent swimmers and there are two professional lifeguards. The rescue is within the competence of all of the one hundred swimmers and entails the same level risk to each. Clearly the lifeguards should effect a rescue, for they are either being paid to do so or have explicitly accepted the obligation to do so. But suppose they stay in their deck-chairs applying more sun oil. All competent swimmers (including the lifeguards) have an obligation to affect the rescue; but, so long as one or two people attempt it, this discharges the obligation for all. It would be pointless both in terms of waste, and perhaps dysfunctional, if all one hundred plunged into the water getting into each other's way and causing confusion. But so long as one person goes, or perhaps for safety two, then the individual and collective responsibilities of all are discharged. Note that those who are not professional lifeguards are not in any way absolved from their responsibility by the existence and presence of such lifeguards. Suppose now that the child is successfully brought to shore, and one of the present authors is the only medically qualified person on the beach. The child needs skilled attention and the obligation to help falls, among others, on both of the authors of this present work. One best discharges that obligation by keeping his clumsy fingers away from the patient while the other (one hopes) is willing to lend his skills to complete the rescue. The obligation that falls on each is the same but only one of the two, and in this case one of the two hundred, has the requisite skills. It is usually held that 'ought implies can', but this may well be one of the circumstances in which this dictum should be reversed. Here 'can implies ought', and the person who is best able to help the child is the one who should do it.

On this view, a person acquires obligations to assume specific risks when he acquires the skills to help people who

are in need of rescue and this rescue happens to involve risks. Thus it is not membership of a profession which generates the obligation, but the possession of the skills of a professional. A doctor who has been struck off still has the same moral obligations to help and incur risks as long as he or she possesses the requisite skills.

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