

Beyond the Call of Duty: Compelling Health Care Professionals to Work During an Influenza Pandemic

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ABSTRACT: In anticipation of pandemics and other mass disasters, several states have enacted little-known laws that authorize government officials to order health care professionals to work during declared public-health emergencies, even when doing so could pose life-threatening risks. Health care professionals who violate these orders could face substantial penalties, ranging from license revocations to fines and imprisonment. The penalties would apply even to individuals whose jobs do not normally involve clinical responsibilities, as well as to health care professionals who are retired or taking time off from work to care for their families. This Article argues that these laws impose burdens that exceed the ethical commitments individuals make when they accept a professional license. In so doing, they compel health care professionals to engage in what is normally considered supererogatory behavior—i.e., acts that are commendable if done voluntarily, but that go beyond what is expected.

In making this argument, the Article rejects commonly made assertions about health care professionals' ethical obligations, including the claim that health care professionals "assume the risk" of infection, that a "social contract" requires health care professionals to work despite potential health risks, and that individuals who have urgently needed skills have an obligation to use them. It concludes that, while it is legitimate to sanction health care professionals for violating voluntarily assumed employment or contractual agreements, they should not be compelled to assume life-

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threatening risks based solely on their status as licensed professionals. In place of singling out health care professionals for punitive measures, the Article argues that policymakers should institute mechanisms to promote volunteerism.

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INTRODUCTION

While it is impossible to predict when the next influenza pandemic will begin, many experts believe that the chances of one starting now are greater than at any time since 1968, when the last of the previous century's three pandemics occurred.¹ An effective response to a pandemic will depend on the willingness of physicians, nurses, and other health care professionals to care for people who have been exposed to the virus. Yet, individuals who do this are likely to face a significantly heightened risk of becoming infected.² Should health care professionals be required to work during a pandemic even if doing so might cost them their lives?

Lawmakers increasingly are deciding that they should be. Following the recommendations of the Model State Emergency Health Powers Act ("MSEHPA"),³ several states have enacted laws that give public-health officials the authority to order health care professionals to work during a pandemic or other public-health emergency.⁴ Individuals who refuse to comply with these orders can have their professional licenses rescinded.⁵ Some states go further than the MSEHPA's recommendations by authorizing fines for and imprisonment of health care professionals who are unwilling to work during a declared public-health emergency.⁶ These penalties would apply even to individuals who do not work in jobs that normally involve clinical responsibilities, and even to health care professionals who are retired or taking time off from work to care for their families.

This Article argues that laws requiring all health care professionals to work during pandemics regardless of their pre-existing treatment obligations impose burdens that exceed the ethical commitments individuals make when they accept a professional license. Health care professionals are not, in other words, simply being asked to fulfill their part of a bargain they freely accepted. Instead, these laws compel health care professionals to engage in what is normally considered supererogatory behavior—i.e., acts that are commendable if done voluntarily, but that go beyond what is expected. Lawmakers have not met their burden of

1. R.J. Webby & R.G. Webster, *Are We Ready for Pandemic Influenza?*, 302 SCI. 1519, 1519 (2003).

2. *See infra* Part I.B (discussing the likely impact of a pandemic on health care professionals).

3. MODEL STATE EMERGENCY HEALTH POWERS ACT (Ctr. for Law & the Public's Health, Georgetown & Johns Hopkins Univs., Discussion Draft 2001), *available at* <http://www.public.healthlaw.net/MSEHPA/MSEHPA2.pdf>.

4. *See infra* notes 129–37 and accompanying text (discussing the MSEHPA and state laws based on it).

5. *See infra* note 130 and accompanying text.

6. *See infra* note 137 and accompanying text.

demonstrating why singling out health care professionals in this manner is ethically justifiable.

In making this argument, this Article departs from commonly asserted claims about health care professionals' ethical obligations. Many medical associations⁷ and academic commentators⁸ maintain that health care professionals have an inherent ethical obligation to treat patients during disasters, regardless of the health care professionals' job responsibilities or potential personal dangers. Common arguments in support of this position are that health care professionals "assume the risk" of infection,⁹ that a "social contract" requires health care professionals to work despite potential health risks,¹⁰ and that individuals who have urgently needed skills have an obligation to use them.¹¹

However, the claim that all health care professionals have an ethical obligation to work during a pandemic, regardless of their actual job responsibilities, does not stand up to scrutiny. While some health care professionals assume a risk of infection by virtue of their employment or contractual agreements, simply *being* a health care professional is not itself evidence of an assumption of risk.¹² Nor is it persuasive to assert that a social contract requires all health care professionals to work during infectious-disease outbreaks. Health care professionals do incur obligations to society in exchange for benefits like subsidized medical education, but there is no reason to assume that the only way they can satisfy these obligations is by exposing themselves to life-threatening risks.¹³ Finally, the fact that health care professionals have special skills that will be valuable during a pandemic does not justify requiring all professionals to work regardless of their pre-existing treatment responsibilities. In general, having special skills does not create an obligation to use them, particularly when doing so would be dangerous.¹⁴ Even if one believes that the obligation to assume risks for the benefit of others is heightened in disaster situations, that belief does not justify imposing a heightened duty solely on individuals who happen to work in health care without imposing similar obligations on others whose contributions could be equally important.¹⁵

In criticizing broad requirements for health care professionals to work during pandemics regardless of their pre-existing treatment responsibilities,

7. See *infra* notes 67–68 and accompanying text (noting the positions of the American Medical Association and the World Medical Association).

8. See *infra* Part III.A.

9. See *infra* Part III.A.1.

10. See *infra* Part III.A.2.

11. See *infra* Part III.A.3.

12. See *infra* Part III.A.1.

13. See *infra* Part III.A.2.

14. See *infra* Part III.A.3.

15. See *infra* Part III.A.3.

this Article is making an ethical argument, not a constitutional one. Specifically, the claim is that such requirements subject health care professionals to burdens that cannot be justified by the commitments individuals make when they accept a professional license. This Article recognizes that, although particular applications of mandatory-work statutes could raise constitutional issues, wholesale constitutional challenges to these statutes are unlikely to be successful.¹⁶ Nonetheless, states have the constitutional authority to do many things that do not necessarily represent wise public policy from an ethical perspective. The goal of this Article is to make clear that even if lawmakers have the power to enact statutes that give public-health officials the discretion to compel health care professionals to work during a pandemic, they should refrain from using their power in this way.

Part I of this Article provides background on the risk of a pandemic, the potential impact of a pandemic on the health care system, and health care professionals' historical response to infectious-disease outbreaks. Part II examines general legal obligations applicable to health care professionals during pandemics, including those based on employment relationships, contractual requirements, federal statutes, and state licensing standards. This Part concludes that health care professionals who fail to fulfill pre-existing treatment obligations during a pandemic could be subject to significant penalties even without a mandatory-work statute.

Part III, the heart of the Article, turns to statutes that impose special penalties on health care professionals who refuse to work during a pandemic independent of any pre-existing treatment responsibilities. It first considers whether these statutes can be justified as mechanisms for enforcing health care professionals' inherent ethical obligations. In doing so, Part III evaluates the three primary arguments that have been advanced for recognizing such an obligation—assumption of risk, social contract, and special skills. It concludes that none of these arguments supports a broad duty to work during a pandemic based solely on one's status as a licensed health care professional. Part III then examines whether laws requiring health care professionals to work during a pandemic are vulnerable to constitutional challenges under the Thirteenth Amendment or the Due Process Clause. This Part concludes that states probably have the constitutional authority to enact the statutes as a general matter, but that certain applications of the statutes would be constitutionally problematic.

Finally, Part IV examines alternatives that policymakers could adopt to address the potential shortage of health care professionals during a pandemic. These include offering positive incentives—both nonfinancial and, in some circumstances, financial—to volunteers; instituting mechanisms to reduce and respond to the risks of volunteering; enacting

16. See *infra* Part III.B.

liability protections; and encouraging a professional norm in favor of volunteerism. While these approaches would require a greater investment of resources than would mandatory-work statutes, they would avoid the ethical problems associated with a punitive approach.

I. BACKGROUND

A. THE PANDEMIC RISK

A pandemic is a global outbreak of disease at levels that substantially exceed those that would normally be expected.¹⁷ Influenza pandemics have occurred regularly throughout human history, typically several times each century.¹⁸ The most serious pandemic on record was the Spanish flu of 1918, which killed at least fifty million people worldwide,¹⁹ including approximately 670,000 people in the United States.²⁰ Smaller pandemics in 1957 and 1968 led to the deaths of about two million and one million people, respectively.²¹

According to the World Health Organization (“WHO”), an influenza pandemic occurs when three conditions are met: “a new influenza virus subtype emerges; it infects humans, causing serious illness; and it spreads easily and sustainably among humans.”²² The H5N1 strain of the avian flu virus already meets the first two of these conditions. As of March 5, 2008, WHO had recorded 371 human cases of the H5N1 virus, 235 of which resulted in death.²³ Widespread human-to-human transmission of the H5N1 virus has not yet developed, but isolated cases are suspected to have occurred.²⁴

17. See United States Department of Health and Human Services, Glossary, <http://pandemicflu.gov/glossary/index.html#P> (last visited Sept. 22, 2008).

18. See John G. Bartlett, *Planning for Avian Influenza*, 145 ANNALS INTERNAL MED. 141, 141 (2006) (noting that pandemic influenza historically has occurred at intervals of eleven to forty-two years and that influenza experts have consistently warned that another pandemic is inevitable).

19. See Jeffery K. Taubenberger & David M. Morens, *1918 Influenza: The Mother of All Pandemics*, 12 EMERGING INFECTIOUS DISEASES 15, 15 (2006) (“Total deaths were estimated at [approximately] 50 million and were arguably as high as 100 million.” (citations omitted)).

20. N. Pieter M. O’Leary, *Cock-a-Doodle-Do: Pandemic Avian Influenza and the Legal Preparation and Consequences of an H5N1 Influenza Outbreak*, 16 HEALTH MATRIX 511, 520 (2006).

21. World Health Org., *Ten Things You Need to Know About Pandemic Influenza* (Oct. 14, 2005), <http://www.who.int/csr/disease/influenza/pandemic10things/en/>.

22. World Health Org., *Avian Influenza Frequently Asked Questions* (Dec. 5, 2005), http://www.who.int/csr/disease/avian_influenza/avian_faqs/en/index.html.

23. World Health Org., *Cumulative Number of Confirmed Human Cases of Avian Influenza A/(H5N1) Reported to WHO* (Mar. 5, 2008), http://www.who.int/csr/disease/avian_influenza/country/cases_table_2008_03_05/en/index.html.

24. Writing Comm. of the Second World Health Org. Consultation on Clinical Aspects of Human Infection with Avian Influenza A (H5N1) Virus, *Update on Avian Influenza A (H5N1) Virus Infection in Humans*, 358 NEW ENG. J. MED. 261, 261 (2008) [hereinafter WHO, *Update*].

While some experts believe that efficient human-to-human transmission of the H5N1 virus is unlikely to develop,²⁵ others point out that “[e]ach additional human case gives the virus an opportunity to improve its transmissibility in humans, and thus develop into a pandemic strain.”²⁶ Moreover, even if the H5N1 virus does not turn out to be the next source of pandemic influenza, another virus almost certainly will. According to most experts, “it is not a question of if but when another influenza pandemic as deadly as the Spanish flu will occur.”²⁷

The severity of the next pandemic cannot be known in advance, but even a mild pandemic could lead to an estimated 2 to 7.4 million deaths worldwide.²⁸ Extrapolating from the mortality rates of the Spanish flu, a serious pandemic could kill as many as sixty-two million people—more than the number of people who die annually from all other causes combined.²⁹ Indeed, the number of deaths could be substantially higher than that figure, as factors like increased population density and more frequent travel could make the next pandemic more infectious than pandemics of the past.³⁰

Most pandemic planners are preparing for significant morbidity and mortality. The U.S. government, for example, is basing its plans on the assumption that, in a severe pandemic, thirty percent of the population will become ill, millions of people will require hospitalization, and nearly two million people will die.³¹ Projections of a serious pandemic are based in part on what is already known about the H5N1 virus.³² Even though human cases

25. See Dennis Normile, *Pandemic Skeptics Warn Against Crying Wolf*, 310 SCI. 1112, 1112 (2005).

26. World Health Org., *supra* note 22.

27. Vickie J. Williams, *Fluconomics: Preserving Our Hospital Infrastructure During and After a Pandemic*, 7 YALE J. HEALTH POL'Y L. & ETHICS 99, 100 (2007); see also Jeffery K. Taubenberger et al., *The Next Influenza Pandemic: Can It Be Predicted?*, 297 JAMA 2025, 2026 (2007) (“It is currently impossible to predict the emergence of a future pandemic other than to strongly suspect that one will eventually occur . . .”).

28. World Health Org., *supra* note 22.

29. Christopher J.L. Murray et al., *Estimation of Potential Global Pandemic Influenza Mortality on the Basis of Vital Registry Data from the 1918–20 Pandemic: A Quantitative Analysis*, 368 LANCET 2211, 2214 (2006).

30. See Hillary R. Ahle, *Anticipating Pandemic Avian Influenza: Why the Federal and State Preparedness Plans Are for the Birds*, 10 DEPAUL J. HEALTH CARE L. 213, 221 (2007) (exploring why current preparedness plans leave the world vulnerable to mass death in the event of a flu epidemic); see also Michael T. Osterholm, *Preparing for the Next Pandemic*, 84 FOREIGN AFF. 24, 24–26 (2005) (suggesting that a pandemic similar to the Spanish flu could result in 180 million to 360 million deaths worldwide, which would be “more than five times the cumulative number of documented AIDS deaths”); Taubenberger & Morens, *supra* note 19, at 21 (“Even with modern antiviral and antibacterial drugs, vaccines, and prevention knowledge, the return of a pandemic virus equivalent in pathogenicity to the virus of 1918 would likely kill [more than] 100 million people worldwide.”).

31. United States Department of Health and Human Services, *Pandemic Planning Assumptions*, <http://pandemicflu.gov/plan/pandplan.html> (last visited Sept. 22, 2008).

32. WHO, *Update*, *supra* note 24, at 262.

of H5N1 remain relatively uncommon, the death rate of reported cases is alarmingly high—over 60%,³³ as compared to only around 2.5% during the Spanish flu.³⁴ Moreover, like the Spanish flu (and unlike seasonal influenza), most victims of the H5N1 virus have been previously healthy adolescents and young adults.³⁵

B. THE POTENTIAL IMPACT OF A PANDEMIC ON THE HEALTH CARE SYSTEM

Responding to a pandemic will place a significant strain on the health care system. Hospitals, public-health agencies, and individual providers will play key roles in distributing antiviral medications and, as they become available, vaccines. Hospitals will also need to find space to treat infected patients and, possibly, to quarantine individuals who are not sick but who may have been exposed to the virus.³⁶ With many hospitals already stretching the limits of their capacity,³⁷ it is hard to see how they will be able to cope with this excess demand.³⁸

Among the many challenges that the health care system will face during a pandemic, one of the greatest will be ensuring an adequate supply of health care professionals. Hospitals already confront severe shortages of skilled health care workers, particularly nurses.³⁹ During a pandemic, the number of available health care professionals will be even smaller than usual, as some people will have to leave the workforce because of infection.⁴⁰ As a result, governments and health care facilities may need to call upon

33. *Id.* at 261–62. Some experts caution that estimates of extremely high mortality rates for H5N1 may be misleading, as individuals with mild cases of the virus may not have sought medical care. *See* N.Y. STATE TASK FORCE ON LIFE & THE LAW, N.Y. STATE DEP'T OF HEALTH, ALLOCATION OF VENTILATORS IN AN INFLUENZA PANDEMIC: PLANNING DOCUMENT 8 (draft for public comment 2007), http://www.health.state.ny.us/diseases/communicable/influenza/pandemic/ventilators/docs/ventilator_guidance.pdf.

34. Taubenberger & Morens, *supra* note 19, at 15.

35. *See* WHO, *Update*, *supra* note 24, at 261–62.

36. *See* Williams, *supra* note 27, at 111 (explaining that if a pandemic occurred, hospitals would be completely overwhelmed).

37. *See* Laura D. Hermer, *The Scapegoat: EMTALA and Emergency Department Overcrowding*, 14 J.L. & POL'Y 695, 716–17 (2006) (“Ninety percent of our larger hospitals have saturated their capacity for treating patients, primarily because of the lack of inpatient critical care beds and the nurses to staff them.”).

38. It has been estimated that “25 states would run out of hospital beds within 2 weeks of a moderate pandemic flu outbreak.” Tracy Hampton, *Pandemic Flu Planning Falls Short: Many Vulnerabilities in Health Care System*, 297 JAMA 1177, 1178 (2007).

39. *See, e.g.*, Stephen Spotswood, *Health Care Worker Shortage a Global Phenomenon*, U.S. MED., Mar. 2006, available at <http://www.usmedicine.com/article.cfm?articleID=1280&issueID=85> (describing the shortage of nurses). According to a July 2007 American Hospital Association report, hospitals had an estimated 116,000 nursing vacancies, which translated into a national nurse vacancy rate of over eight percent. AM. ASS'N OF COLLS. OF NURSING, NURSING SHORTAGE FACT SHEET 1 (2008), available at <http://www.aacn.nche.edu/Media/pdf/NrsgShortageFS.pdf>.

40. *See* Hampton, *supra* note 38, at 1178 (“Staff shortages may be exacerbated by the likely event that more health care professionals than workers in the general public will fall ill.”).

qualified individuals who are not currently working or ask workers to perform tasks that are not normally part of their jobs.⁴¹

Health care professionals who participate in the pandemic response effort are likely to face a significantly greater risk of infection than the rest of the population. Influenza infections among health care professionals are common during periods of seasonal outbreaks, due to the ease with which the disease is transmitted through casual contact, its short incubation period, and the fact that persons can transmit the disease even before they begin to show symptoms.⁴² Individuals who work with particular subgroups of patients—including children, the elderly, and persons who are immunocompromised—face an especially high risk of becoming infected.⁴³ While vaccination can significantly reduce the risk to health care professionals,⁴⁴ experts predict it will take several months from the outbreak of a pandemic before a vaccine targeted to the pandemic virus is available.⁴⁵

The Severe Acute Respiratory Syndrome (“SARS”) epidemic of 2003, which resulted in 8098 infections and 774 deaths worldwide,⁴⁶ underscores the risks to health care professionals of working during an infectious-disease outbreak. Health care professionals accounted for approximately twenty percent of confirmed cases of SARS worldwide; in some areas, the figure was over forty percent.⁴⁷ Implementation of infection-control measures in hospitals significantly reduced the risks to health care professionals, but some workers were infected despite having used all available protective equipment.⁴⁸

41. See James G. Hodge, Jr. et al., *The Legal Framework for Meeting Surge Capacity Through the Use of Volunteer Health Professionals During Public Health Emergencies and Other Disasters*, 22 J. CONTEMP. HEALTH L. & POL’Y 5, 7–8 (2005) (describing the need for volunteer health professionals in emergency situations).

42. COMM. ON PERS. PROTECTIVE EQUIP. FOR HEALTHCARE WORKERS DURING AN INFLUENZA PANDEMIC, INST. OF MED. OF THE NAT’L ACADS., *PREPARING FOR AN INFLUENZA PANDEMIC: PERSONAL PROTECTIVE EQUIPMENT FOR HEALTHCARE WORKERS* 61 (Lewis R. Goldfrank & Catharyn T. Liverman eds., 2008) [hereinafter PERSONAL PROTECTIVE EQUIPMENT].

43. *Id.* at 62–63.

44. *Id.* at 61.

45. World Health Org., *supra* note 22; see also Y. Guan et al., *A Model to Control the Epidemic of H5N1 Influenza at the Source*, BMC INFECTIOUS DISEASES, Nov. 13, 2007, <http://www.biomedcentral.com/content/pdf/1471-2334-7-132.pdf> (“[A]t most only a third of the global human population may have the chance of getting the vaccine at least six months after the pandemic strain is identified.”).

46. WORLD HEALTH ORG., WHO GUIDELINES FOR THE GLOBAL SURVEILLANCE OF SEVERE ACUTE RESPIRATORY SYNDROME (SARS) 6 (2004), available at http://www.who.int/csr/resources/publications/WHO_CDS_CSR_ARO_2004_1.pdf.

47. WORLD HEALTH ORG., CONSENSUS DOCUMENT ON THE EPIDEMIOLOGY OF SEVERE ACUTE RESPIRATORY SYNDROME (SARS) 14 (2003), available at http://www.who.int/csr/sars/en/WHO_consensus.pdf; see also Ezekiel J. Emanuel, *The Lessons of SARS*, 139 ANNALS INTERNAL MED. 589, 590 (2003) (“More than half of the first 60 reported cases of SARS involved health care workers who had come into contact with SARS patients.”).

48. See WORLD HEALTH ORG., *supra* note 47, at 19.

C. HEALTH CARE PROFESSIONALS' HISTORICAL RESPONSE TO
INFECTIOUS-DISEASE OUTBREAKS

The historical record of health care professionals' response to infectious-disease outbreaks has focused largely on physicians, whose response has been described as "erratic."⁴⁹ During the plagues of Europe, many physicians stayed in affected areas to attend to their patients, but others fled.⁵⁰ Some evidence suggests that "flight in the face of plague was regarded, both by physicians and the public at large, as a dereliction of duty and a shameful thing."⁵¹ However, the fact that some municipalities saw it necessary to enact laws forbidding physicians from leaving during epidemics⁵² suggests that this sense of duty may not have been universally accepted by all physicians.⁵³

By the mid-nineteenth century, however, stories of physicians fleeing infectious-disease outbreaks became rarer. At this point, "tales of heroism eclipse accounts of flight as a sense of individual duty became indisputably rooted in the medical conscience."⁵⁴ The American Medical Association's ("AMA") first Code of Ethics ("Code"), released in 1847, reflected this self-sacrificing ethos. As stated in the 1847 Code: "'When 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."⁵⁵ This provision, with minor modifications, remained in the Code for 130 years.⁵⁶

Given the day-to-day realities of medical practice before the mid-twentieth century, it is easy to understand why physicians thought that risking their lives was an essential part of their profession. For example, new

49. Samuel J. Huber & Matthew K. Wynia, *When Pestilence Prevails . . . Physician Responsibilities in Epidemics*, AM. J. BIOETHICS, Winter 2004, at W5, W5, available at http://www.bioethics.net/journal/pdf/4_1_IF_w05_Huber.pdf.

50. *Id.* at W6; see also Darrel W. Amundsen, *Medical Deontology and Pestilential Disease in the Late Middle Ages*, J. HIST. MED. & ALLIED SCI. 403, 404 (1977) ("For every account . . . of a physician hiding in terror, . . . there are descriptions . . . of physicians trying desperately to help their patients . . ."); Daniel M. Fox, *The Politics of Physicians' Responsibility in Epidemics: A Note on History*, HASTINGS CENTER REP. (SPECIAL SUPPLEMENT), Apr.-May 1988, at 5, 5 (noting physicians' differing responses to epidemics throughout history).

51. John D. Arras, *The Fragile Web of Responsibility: AIDS and the Duty to Treat*, HASTINGS CENTER REP. (SPECIAL SUPPLEMENT), Apr.-May 1988, at 10, 13.

52. See Fox, *supra* note 50, at 6 (noting that, in response to plagues, "[p]hysicians were forbidden to leave some cities and their hinterlands").

53. See Abigail Zuger & Steven H. Miles, *Physicians, AIDS, and Occupational Risk: Historic Traditions and Ethical Obligations*, 258 JAMA 1924, 1924 (1987) (concluding that "the dominant impression that this diverse group left among its contemporaries was not one of heroism").

54. Arras, *supra* note 51, at 14.

55. Huber & Wynia, *supra* note 49, at W6 (alteration in original) (quoting THE AMERICAN MEDICAL ETHICS REVOLUTION: HOW THE AMA'S CODE OF ETHICS HAS TRANSFORMED PHYSICIANS' RELATIONSHIPS TO PATIENTS, PROFESSIONALS, AND SOCIETY 333 (Robert B. Baker et al. eds., 1999)).

56. See *id.* at W7.

medical students between 1920 and 1940 faced a one-in-ten risk of developing active tuberculosis; for pulmonologists, “having spent time as a patient in a tuberculosis sanatorium appears to have been a near-ubiquitous experience into the 1950s.”⁵⁷ Under these circumstances, individuals who were unwilling to accept a significant risk of developing a serious infection would probably not have considered a career in medicine.

This situation changed with the advent of antibiotics in the 1950s. With the prevalence of infectious disease dramatically declining, the medical profession no longer had any reason to consider going to work an inherently risky endeavor. The AMA’s Code reflected these developments. By 1957, the provisions on the duty to treat during infectious-disease outbreaks had been downgraded from a principle to an “interpretive note,” and in 1977, the AMA removed the provision completely.⁵⁸ The AMA’s elimination of this provision reflected not only changed medical circumstances, but also the organized medical profession’s increasing effort to assert its autonomy in the face of external regulation.⁵⁹

Physicians’ willingness to treat infectious patients did not become a significant issue again until the emergence of HIV in the early 1980s, when some physicians declared that they would not treat patients known or suspected to be HIV-positive.⁶⁰ The AMA’s initial response to the HIV epidemic was markedly different from its approach to the infectious-disease outbreaks of the previous century. In its first statement on the issue, in 1986, the AMA noted physicians’ historic “compassion and courage” in caring for patients with infectious diseases but then went on to say that physicians should care for HIV-positive patients only if they were “emotionally able” to do so.⁶¹ Following extensive criticism,⁶² the AMA quickly reversed course

57. *Id.*

58. *Id.*

59. *See id.* (noting that “concerns about government and corporate intrusions into the medical practice,” as well as the fact that “the era of massive epidemics was perceived to be ending,” were “major factors [that] led to a waning acceptance of the duty to treat . . . contagious patients”).

60. *See* Molly Cooke, *Physician Risk and Responsibility in the HIV Epidemic*, 152 W.J. MED. 57, 59 (1990) (noting that the chief of orthopedic surgery at a San Francisco hospital maintained “that the care of HIV-infected persons is extremely dangerous and that physicians should not be required to provide it”); Norman Daniels, *Duty to Treat or Right to Refuse?*, HASTINGS CENTER REP., Mar.–Apr. 1991, at 36, 36 (“[T]he National Commission on AIDS complained that ‘a shocking number of physicians are reluctant to take care of people living with HIV infection and AIDS.’”); Jennifer O’Flaherty, *The AIDS Patient: A Historical Perspective on the Physician’s Obligation to Treat*, PHAROS, Summer 1991, at 13, 13 (quoting one physician as stating that “‘expos[ing] myself to that risk at this point in my life when I’m responsible for a newborn child is something I don’t want to do’”).

61. Benjamin Freedman, *Health Professions, Codes, and the Right to Refuse to Treat HIV-Infected Patients*, HASTINGS CENTER REP. (SPECIAL SUPPLEMENT), Apr.–May 1988, at 20, 22.

62. *See* Huber & Wynia, *supra* note 49, at W8 (noting that the AMA position “was widely ridiculed”).

and declared that “[a] physician may not ethically refuse to treat a patient whose condition is within the physician’s current realm of competence solely because the patient is seropositive for HIV.”⁶³ Nonetheless, because the statement was phrased as a limitation on the circumstances in which a physician could ethically deny treatment to an otherwise eligible patient—i.e., as an anti-discrimination principle⁶⁴—it was limited to physicians whose jobs already brought them into contact with patients who were HIV-positive. It did not create an obligation for physicians to affirmatively seek out HIV-positive patients. Moreover, given that HIV-positive patients pose a very low risk to physicians if adequate protective measures are taken,⁶⁵ it could not be interpreted as creating a broad duty to treat regardless of personal risk.⁶⁶

The AMA’s 2004 pronouncement on physicians’ obligations during “epidemics, terrorist attacks, and other disasters” was therefore particularly significant. Returning to its earliest statements on physicians’ ethical responsibilities, the AMA declared that “individual physicians have an obligation to provide urgent medical care during disasters” and expressly stated that “[t]his ethical obligation holds even in the face of greater than usual risks to their own safety, health or life.”⁶⁷ Other professional medical associations have issued similar statements.⁶⁸

63. COUNCIL ON ETHICAL & JUDICIAL AFFAIRS, AM. MED. ASS’N, CODE OF MEDICAL ETHICS: CURRENT OPINIONS WITH ANNOTATIONS § 9.131 (2008) [hereinafter AMA CODE OF ETHICS].

64. See Huber & Wynia, *supra* note 49, at W8 (“[P]rofessional consensus emerged around *non-discrimination* as the fundamental basis on which to support a duty to treat HIV-infected patients.” (citations omitted)).

65. See Ctrs. for Disease Control & Prevention, U.S. Dep’t of Health & Human Servs., Are Health Care Workers at Risk of Getting HIV on the Job?, <http://www.cdc.gov/hiv/resources/qa/qa28.htm> (last visited Sept. 23, 2008) (“The risk of health care workers being exposed to HIV on the job is very low, especially if they carefully follow universal precautions (i.e., using protective practices and personal protective equipment to prevent HIV and other blood-borne infections).”).

66. See Huber & Wynia, *supra* note 49, at W8 (relying in part on the low risk of HIV transmission to conclude that “the profession largely avoided re-endorsing a broad duty to treat during epidemics”).

67. AMA CODE OF ETHICS, *supra* note 63, § 9.067. The AMA’s Council on Ethical and Judicial Affairs has clarified that physicians’ obligation to assume risk is not unlimited. See Karine Morin et al., *Physician Obligation in Disaster Preparedness and Response*, 15 CAMBRIDGE Q. HEALTHCARE ETHICS 417, 420 (2006) (stating, on behalf of the Council of Ethical and Judicial Affairs, that “[p]hysicians should not be expected to place themselves at greater risk than the benefit they can provide”).

68. See, e.g., WORLD MED. ASS’N, STATEMENT ON AVIAN AND PANDEMIC INFLUENZA § 11(h) (2006), available at <http://www.wma.net/e/policy/a28.htm> (“Physicians have an ethical responsibility to provide services to the injured or ill. They should have resources in place in the event they and/or their own families become infected.”). Some medical associations have remained silent on the expectations of physicians in disaster situations. See Carly Ruderman et al., *On Pandemics and the Duty to Care: Whose Duty? Who Cares?*, BMC MED. ETHICS, Apr. 20, 2006, <http://www.biomedcentral.com/content/pdf/1472-6939-7-5.pdf> (noting that the Canadian Medical Association’s revised Code of Ethics, released in 2004, “is, quite astoundingly, altogether silent on physicians’ duty to care”).

In contrast to these statements on physicians' responsibilities, professional nursing associations have taken a more ambiguous position. The American Nurses Association ("ANA"), for example, has observed that "[h]istorically, nurses have given care to those in need, even at risk to their own health, life, or limb," but that "in certain situations the risks of harm may outweigh a nurse's moral obligation or duty to care for a given patient."⁶⁹ According to the ANA, nurses have an obligation to care only if "[t]he benefit the patient will gain outweighs any harm the nurse might incur and does not present more than an acceptable risk to the nurse."⁷⁰ The ANA's statement does not define the term "acceptable risk," but instead calls on individual nurses to make their own judgments based on "critical thinking and ethical analysis."⁷¹

It is not clear what impact these professional statements have had on the attitudes of individual health care professionals. In a survey of physicians' attitudes about a potential smallpox outbreak, only forty percent of respondents said that they would be willing to work in situations that posed a risk of infection.⁷² Similarly, only half of New York City physicians reported that they would be willing to work during a SARS outbreak.⁷³ Numerous other surveys, both in the United States and in other countries, have produced comparable results.⁷⁴ Based in part on health care professionals' self-reported attitudes, many government planners "have little confidence in health care professionals' willingness to remain at work in the face of danger."⁷⁵

Health care professionals' actual behavior during the SARS epidemic, however, paints a more promising picture. While some health care

69. COMM. ON ETHICS, AM. NURSES ASS'N, RISK AND RESPONSIBILITY IN PROVIDING NURSING CARE (rev. position statement 2006) (on file with the Iowa Law Review).

70. *Id.*

71. *Id.*

72. See *Infection Control Update: Who Will Come to Work in a Pandemic?*, HEALTHCARE PURCHASING NEWS, Jan. 2007, at 36, 36.

73. K. Qureshi et al., *Health Care Workers' Ability and Willingness to Report to Duty During Catastrophic Disasters*, 82 J. URB. HEALTH 378, 383 (2005).

74. See, e.g., Niklas Mackler et al., *Will First-Responders Show Up for Work During a Pandemic? Lessons from a Smallpox Vaccination Survey of Paramedics*, 5 DISASTER MGMT. & RESPONSE 45, 46 tbl.1 (2007) (finding that only thirty-nine percent of paramedics would remain on duty during a smallpox pandemic if no vaccine were available); R.D. Balicer et al., *Local Public Health Professionals' Perceptions Toward Responding to an Influenza Pandemic*, BMC PUB. HEALTH, Apr. 18, 2006, <http://www.biomedcentral.com/content/pdf/1471-2458-6-99.pdf> (finding that nearly half of local health department workers in Maryland would not report to work during a pandemic); Boris P. Ehrenstein et al., *Influenza Pandemic and Professional Duty: Family or Patients First? A Survey of Hospital Employees*, BMC PUB. HEALTH, Dec. 28, 2006, <http://www.biomedcentral.com/content/pdf/1471-2458-6-311.pdf> (reporting that twenty-eight percent of employees at a university hospital in Germany agreed that it would be acceptable for health care professionals to abandon their workplaces during a pandemic).

75. Kenneth V. Iserson et al., *Fight or Flight: The Ethics of Emergency Physician Disaster Response*, 51 ANNALS EMERGENCY MED. 345, 346 (2008).

professionals resigned from their jobs because of SARS,⁷⁶ the overall response of health care professionals “was generally regarded as exemplary.”⁷⁷ The SARS experience suggests that health care professionals’ responses to hypothetical survey questions are not necessarily accurate indicators of how they would respond in the event of a crisis.

II. GENERAL LEGAL OBLIGATIONS APPLICABLE TO HEALTH CARE PROFESSIONALS DURING PANDEMICS

Even without laws authorizing public-health officials to order health care professionals to work during emergencies, some health care professionals would have obligations to work during a pandemic based on employment requirements, contractual agreements, and/or generally applicable health care statutes and regulations. This Part examines the nature of these obligations and how the existence of a pandemic might affect them. It concludes that health care professionals who fail to fulfill pre-existing treatment obligations during a pandemic could face significant penalties even in the absence of a statute authorizing mandatory orders to work during public-health emergencies. In contrast, individuals who have not previously committed to treating patients would not be required to assume such responsibilities simply because their services are in need.

A. EMPLOYMENT-RELATED OBLIGATIONS

For health care professionals who are employees, such as nurses in a hospital, there is one obvious potential consequence of not showing up to work during a pandemic: they could lose their jobs. There are, however, some circumstances in which employees might have the right to stay away from work during a pandemic without jeopardizing their employment. For example, the Family and Medical Leave Act requires employers with more than fifty employees to give workers up to twelve weeks of unpaid time off to care for an immediate family member with a “serious health condition.”⁷⁸ The statute would therefore appear to protect employees who stay home during a pandemic to care for a sick relative.

76. MARK A. ROTHSTEIN ET AL., INST. FOR BIOETHICS, HEALTH POLICY & LAW, UNIV. OF LOUISVILLE SCH. OF MED., QUARANTINE AND ISOLATION: LESSONS LEARNED FROM SARS 103 (2003), available at <http://louisville.edu/bioethics/public-health/SARS.pdf>; see also Lawrence K. Altman, *Asian Medics Stay Home, Imperiling Respirator Patients*, N.Y. TIMES, Mar. 21, 2003, at A6 (reporting that some hospitals in Vietnam and Hong Kong were operating with half their normal staff).

77. Ruderman et al., *supra* note 68.

78. See 29 U.S.C. §§ 2611(4)(A)(i), 2612(a)(1)(C), (c) (2000). Some states have statutes requiring employers to give workers paid leave for family care. See, e.g., CAL. UNEMP. INS. CODE § 3301(a)(1) (West Supp. 2008).

In addition, labor laws may constrain employers' ability to fire health care professionals during a pandemic.⁷⁹ According to Department of Labor regulations, employees have the right to refuse to work if they face a risk of "serious injury or death arising from a hazardous condition at the workplace" and "there is insufficient time . . . to eliminate the danger through resort to regular statutory enforcement channels."⁸⁰ In addition, the National Labor Relations Act ("NLRA") protects employees from being fired for engaging in concerted action to protest unsafe work conditions.⁸¹ Although hospital workers are not normally permitted to strike unless they provide ten days' notice,⁸² the right to engage in collective protests of unsafe conditions applies even if workers would otherwise be precluded from striking, as the statute provides that refusing to work under "abnormally dangerous conditions" shall not be considered a strike.⁸³ While federal labor laws would not apply to health care professionals who are employed by state or local governments,⁸⁴ many states have laws that protect such employees.⁸⁵

It is not clear that courts would be willing to apply these labor-law protections to health care professionals who refuse to work during infectious-disease outbreaks. First, refusal-to-work laws are part of statutory schemes designed to address unfair labor practices or violations of workplace-safety requirements.⁸⁶ As such, cases addressing these provisions

79. Labor laws provide the minimum floor of protections for all employees. Some employees may be entitled to broader protections than those described in the text as a result of collective-bargaining agreements negotiated with particular employers.

80. 29 C.F.R. § 1977.12(b)(2) (2007); *see also* Whirlpool Corp. v. Marshall, 445 U.S. 1, 22 (1980) (upholding the regulation as a valid exercise of the Secretary of Labor's authority under the Occupational Safety and Health Act).

81. 29 U.S.C. § 157 (2000) (establishing workers' right to engage in concerted activity for "mutual aid or protection"); *see also* NLRB v. Wash. Aluminum Co., 370 U.S. 9, 17 (1962) (holding that employees' refusal to work in an inadequately heated plant was protected concerted activity). The NLRA applies only to collective action; as such, if an individual employee who is not protected by a union refuses to work, she will not be able to invoke the NLRA's protections. *See, e.g.*, Prill v. NLRB, 835 F.2d 1481, 1482–85 (D.C. Cir. 1987) (affirming the NLRB's definition of "concerted activity," which requires that the action be "engaged in with or on the authority of other employees, and not solely by and on behalf of the employee himself" (quoting Meyers Indus., Inc., 268 N.L.R.B. 493, 497(1984))).

82. 29 U.S.C. § 158(g) (2000).

83. *Id.* § 143.

84. *Id.* § 152(2).

85. *See, e.g.*, OHIO REV. CODE ANN. § 4167.06(A) (West 2007).

86. *See* Whirlpool Corp. v. Marshall, 445 U.S. 1, 8 (1980) (recognizing that the Department of Labor's refusal-to-work regulations were designed as a mechanism for enforcing employers' requirements under the Occupational Health and Safety Act); Michael H. LeRoy, *From Docks to Doctor Offices After 9/11: Refusing to Work Under "Abnormally Dangerous Conditions,"* 56 ADMIN. L. REV. 585, 637 (2004) (explaining that a Department of Labor refusal-to-work regulation "aids in the enforcement of the OSHA's safety duties").

generally involve allegations of some type of employer wrongdoing.⁸⁷ Health care employers who fail to provide necessary protective equipment during a pandemic, such as masks and respirators,⁸⁸ might fit within this framework. However, courts may be unwilling to apply these protections in situations involving naturally occurring dangers that the employer is powerless to control.

Second, most of the refusal-to-work laws apply only to employees who object to “abnormally dangerous” working conditions.⁸⁹ They do not give employees the right to refuse to work because of risks that are an inherent part of their jobs.⁹⁰ Whether the risks associated with a pandemic would be considered abnormally dangerous depends on how the concept of abnormality is interpreted. If the reference point is the risks that workers ordinarily encounter in their day-to-day activities, most health care professionals—with the possible exception of paramedics⁹¹—could plausibly claim that working during a pandemic is abnormally dangerous, given that exposure to potentially lethal infections is not an everyday occurrence. However, it is likely that courts would focus not only on the *typical* risks in the workplace but also on the level of *foreseeable* dangers.⁹² Under this approach, working during a pandemic would probably not be considered abnormally dangerous for workers in fields like emergency medicine, where

87. See, e.g., *Whirlpool Corp.*, 445 U.S. at 607 (involving employees who were ordered to walk on a mesh screen suspended twenty feet from the floor, through which another worker had recently fallen to his death); *TNS, Inc.*, 329 N.L.R.B. 602, 609 (1999) (involving allegations that workers in a uranium plant were exposed to radiation in amounts “far greater than those typical for the nuclear industry”).

88. See PERSONAL PROTECTIVE EQUIPMENT, *supra* note 42, at 2 (emphasizing the importance of personal protective equipment—including “respirators, gowns, gloves, face shields, [and] eye protection”—during a pandemic).

89. See, e.g., 29 U.S.C. § 143 (2000) (“[T]he quitting of labor . . . because of abnormally dangerous conditions . . . [shall not] be deemed a strike”); OHIO REV. CODE ANN. § 4167.06(A) (West 2007) (protecting public employees’ right to refuse to work only if “such conditions are not such as normally exist for or reasonably might be expected to occur in the occupation of the public employee”). The Department of Labor’s refusal-to-work regulations, however, do not contain a requirement that the imminent danger be “abnormal.” See *Marshall v. Daniel Constr. Co.*, 563 F.2d 707, 722 n.16 (5th Cir. 1977).

90. See *LeRoy*, *supra* note 86, at 640 (“Section 502 does not allow professionals in a high-risk job to pick and choose when to work. This decision is reserved for rare and extreme situations that transcend ordinary occupational risk.”).

91. See *id.* at 625 (concluding that if a court interpreted “abnormally dangerous” based on the “risks inherent in accident scenes worked by paramedics,” there would be “few if any dangerous employment settings” in which paramedics would qualify for protection).

92. The foreseeability standard is explicitly recognized in the Ohio public-employee statute, which provides that employees are not entitled to refuse to work under conditions that “reasonably might be expected to occur.” OHIO REV. CODE ANN. § 4167.06(A).

exposure to contagious diseases is clearly foreseeable.⁹³ Nonetheless, some health care professionals never come near patients with infectious diseases—for example, pathologists, who do not normally interact with patients directly, or physicians and nurses who work in a hospital’s corporate offices. If these individuals are asked to help care for patients during a pandemic, they might be able to convince a court that working would involve abnormally dangerous risks.

Finally, while some courts have been willing to protect professionals who refuse to work based on good-faith, reasonable fears that turn out to be unfounded,⁹⁴ other authorities have suggested that the absence of objective evidence of danger eliminates the protection.⁹⁵ Although it is logical to assume that working during a pandemic will expose health care professionals to a heightened risk of infection,⁹⁶ that assumption may not be true at all phases of the crisis. For example, with a highly infectious virus, at some point, health care professionals who go to work may not face a substantially greater risk of infection than the rest of the population, as everyone in the community may already have been exposed. Health care professionals who refuse to work under such circumstances may lose whatever protection they previously enjoyed from the refusal-to-work laws.

Of course, even if employers have the right to fire health care professionals who refuse to work during a pandemic, they may choose not to exercise this option. If the goal is to ensure that as many workers as possible are available, firing people from their jobs may be seen as counterproductive. Moreover, in areas where the demand for health care professionals exceeds the supply, threatening workers with job dismissal is unlikely to create an incentive to keep working during the pandemic; if a worker loses her job, she could simply get another one once the pandemic is over.

93. As one recent article noted:

Infectious disease risks are an unavoidable result of caring for patients in emergency medicine because many of those infected do not manifest typical signs or symptoms of their diseases. More than 15 types of airborne infections have been transmitted to health care workers, including tuberculosis, varicella, measles, influenza, and respiratory syncytial virus. These cause significant morbidity and occasional mortality.

Iserson et al., *supra* note 75, at 346.

94. *See, e.g.,* Banyard v. NLRB, 505 F.2d 342, 348 (D.C. Cir. 1974) (refusing to apply a “safe-in-fact” standard).

95. *See, e.g.,* Goodyear Tire & Rubber Co. v. Cunningham, 269 N.L.R.B. 881, 881 (1984) (“Section 502 applies only where it has been objectively established that the working conditions are abnormally dangerous.”); *see also* Gateway Coal v. United Mine Workers, 414 U.S. 368, 386 (1974) (dictum) (arguing for the necessity of objective evidence “that such conditions actually obtain”).

96. *See supra* notes 42–48 and accompanying text.

B. CONTRACTUAL OBLIGATIONS

Some health care professionals, whether or not they are employees,⁹⁷ may have contractual obligations to treat patients in emergency situations. For example, a physician may have a contract with a hospital that requires her to be on call for emergency consultations, or a physician's contract with a managed-care organization may require her to take emergency calls from members of a particular health plan. While individuals can be excused from performing their contractual obligations on the grounds of "illness or health danger," this defense applies only if the danger was not foreseeable at the time the parties entered into the contract.⁹⁸ As noted above, the possibility of being exposed to a contagious disease is a foreseeable consequence of assuming emergency-care responsibilities;⁹⁹ as such, the "health-dangers" defense to contract enforcement is unlikely to apply.

Some health care professionals may also have enforceable contracts with individual patients. In the absence of a limiting agreement, a treatment relationship creates an implied contractual obligation of "continuing attention," which means that the health care professional may not end the relationship without giving enough notice to allow the patient to seek treatment elsewhere.¹⁰⁰ Although a relationship that is limited to the treatment of a particular medical problem will automatically end when the problem ceases,¹⁰¹ some professional-patient relationships are more open-

97. Most physicians who are affiliated with hospitals do not work as employees. James A. Brickley & R. Lawrence Van Horn, *Managerial Incentives in Nonprofit Organizations: Evidence from Hospitals*, 45 J.L. & ECON. 227, 231 (2002). In some states, hospitals are not permitted to hire physicians as employees because of prohibitions on the "corporate practice of medicine." Nicole Huberfeld, *Be Not Afraid of Change: Time to Eliminate the Corporate Practice of Medicine Doctrine*, 14 HEALTH MATRIX 243, 253 (2004).

98. See *Handicapped Children's Educ. Bd. v. Lukaszewski*, 332 N.W.2d 774, 777 (Wis. 1983).

99. See *supra* note 93 and accompanying text.

100. See, e.g., *Ricks v. Budge*, 64 P.2d 208, 211-12 (Utah 1937); see also *Norton v. Hamilton*, 89 S.E.2d 809, 812 (Ga. 1955) (stating that a health care professional breaches a tort-based duty if he ends the relationship without "giv[ing] reasonable notice or provid[ing] a competent physician in his place").

101. See MARK A. HALL ET AL., *HEALTH CARE LAW AND ETHICS* 161 (6th ed. 2003) ("[T]he relationship continues as long as the patient needs treatment for the condition that brought the patient to the physician. Once the need is satisfied, the relationship ends."); see also *Blanchette v. Barrett*, 640 A.2d 74, 86 (Conn. 1994). According to *Blanchette*, the factors to consider in determining whether a physician-patient relationship has terminated are:

the subjective views of the parties as to whether their relationship had terminated; the length of their relationship; the frequency of their interactions; the nature of the physician's practice; whether the physician had prescribed a course of treatment for or was monitoring the condition of the patient; whether the patient was relying upon the opinion and advice of the physician with regard to a particular injury, illness or medical condition; and whether the patient had begun

ended. For example, a general practitioner may hold herself out as being available whenever her patients have any medical problems. In so doing, she may be found to have created an ongoing relationship that cannot be terminated without adequate notice. In theory, once a pandemic begins, a general practitioner could notify her existing patients that she will no longer be accepting appointments, but she would have to give her patients sufficient time to make arrangements to find alternative care.¹⁰² As with emergency-care workers, it is doubtful that general practitioners could rely on the “health-dangers” excuse to prevent contract enforcement, as physicians who hold themselves out as being available in all types of medical situations can reasonably foresee being exposed to contagious disease.¹⁰³

Health care professionals who breach a contractual obligation to work during a pandemic could face several types of consequences. First, they could lose any rights they enjoy under their contracts. For example, if a physician breaches a contractual obligation to provide on-call services at a hospital, the hospital could take away the physician’s clinical privileges.¹⁰⁴ Second, health care professionals who breach contractual work requirements could be required to pay for the costs of hiring replacement workers.¹⁰⁵ Finally, in some situations, health care professionals who breach contractual obligations may be required to pay damages to patients or their survivors. This could be true even if the health care professional and the patient are not in a direct contractual relationship. For example, a patient who is unable to obtain treatment from an on-call physician may have a viable legal claim against the physician based on the physician’s contractual

to consult with another physician concerning the same injury, illness or medical condition.

Id. at 86.

102. See *supra* note 100 and accompanying text.

103. See Daniels, *supra* note 60, at 38 (“There is a general understanding that physicians face an increased risk of contagion from disease”). Daniels argues that “[p]hysicians consented to face some standard level of risks when they agreed to enter the profession and trained for it,” but that they did not consent to assume risks beyond this standard level. *Id.* As argued below, this Article rejects the claim that physicians consent to risk solely by virtue of entering the profession. See *infra* Part III.A.1. However, for physicians who have ongoing contractual relationships with patients, Daniels’s argument actually *understates* the scope of the duty to treat. For these physicians, the question would be whether a risk is foreseeable, not whether it is standard. The fact that a risk is not commonly encountered does not mean that it cannot be foreseen.

104. See Clarifying Policies Related to the Responsibilities of Medicare-Participating Hospitals in Treating Individuals with Emergency Medical Conditions, 68 Fed. Reg. 53,222, 53,253 (Sept. 9, 2003) (codified at 42 C.F.R. § 489.24(j) (2008)) (summary of departmental responses to public comments on proposed rule) (“[H]ospitals facing a refusal by physicians to assume on-call responsibilities or to carry out the responsibilities they have assumed could suspend, curtail, or revoke the offending physician’s practice privileges.”).

105. Handicapped Children’s Educ. Bd. v. Lukaszewski, 332 N.W.2d 774, 779 (Wis. 1983).

obligations to the hospital.¹⁰⁶ However, for the patient to recover, she would have to show not only a breach of a contractual obligation but also causation and damages. Thus, if there was nothing the physician could have done to help the patient, or if the patient was able to obtain timely treatment from another physician, the physician would not be required to pay compensation.¹⁰⁷

C. FEDERAL STATUTES

Two federal statutes are potentially relevant to health care professionals who refuse to work during a pandemic. First, under the Emergency Medical Treatment and Active Labor Act (“EMTALA”), physicians who have treatment obligations at a hospital with an emergency room may be subject to civil fines of up to \$50,000 for failing to provide appropriate screening or stabilizing treatment in an emergency.¹⁰⁸ In cases of “gross and flagrant” or repeated violations, the physician can be excluded from participation in the Medicare program.¹⁰⁹ Nothing in EMTALA suggests that physicians could rely on their fear of becoming infected as a defense to these penalties.¹¹⁰ While the Secretary of Health and Human Services has the authority to waive the normal EMTALA sanctions during public-health emergencies,¹¹¹ such waivers are designed to give hospitals flexibility in decisions about transferring patients to alternative facilities.¹¹² They do not appear to apply to physicians who simply fail to show up to the hospital.

Second, individuals who are denied treatment during a pandemic might seek damages under the Americans with Disabilities Act (“ADA”)¹¹³ on the theory that refusing to treat a patient with an infectious disease constitutes a form of disability discrimination. However, such claims would face two significant hurdles. First, not all serious medical conditions

106. See *Hiser v. Randolph*, 617 P.2d 774, 778 (Ariz. 1980) (holding a physician liable for refusing to treat a patient). Canadian courts have gone even further, recognizing a duty to treat based solely on a physician’s physical presence in the hospital, even when the physician is not on-call. See Anne F. Walker, *The Legal Duty of Physicians and Hospitals to Provide Emergency Care*, 166 CANADIAN MED. ASS’N J. 465, 466 (2002).

107. See *Ricks v. Budge*, 64 P.2d 208, 211–12 (Utah 1937) (finding that it was unclear whether the patient suffered damages as result of the physicians refusal to give care).

108. 42 U.S.C. § 1395dd(a)–(b), (d)(1)(B) (2000).

109. *Id.* § 1395dd(d)(1)(B).

110. See Ariel R. Schwartz, Note, *Doubtful Duty: Physicians’ Legal Obligation to Treat During an Epidemic*, 60 STAN. L. REV. 657, 679 (2007) (“[H]ospitals would have a responsibility to treat people with highly infectious diseases if their conditions were deemed to be an emergency because there is no exception under EMTALA for direct threats or significant risks.”).

111. See 42 U.S.C. § 1320b-5(b)(3) (Supp. V 2005).

112. See *id.* (authorizing waivers only for certain “transfer[s] of . . . individual[s] who ha[ve] not been stabilized” or certain “direction[s] or relocation[s] of . . . individual[s] to receive medical screening in an alternate location”).

113. 42 U.S.C. §§ 12101–12213 (2000).

constitute “disabilities” under the ADA.¹¹⁴ In order to satisfy the statute’s narrow definition of “disability,” the plaintiff would have to show that having influenza “substantially limits” a “major life activit[y]”¹¹⁵—such as walking, breathing, or performing manual tasks¹¹⁶—and that this limitation is “permanent or long-term.”¹¹⁷ The “long-term” requirement means that, even if a person infected with influenza is incapable of performing many critical daily functions, she might not be considered disabled if the chances of recovering with treatment are reasonably good.¹¹⁸

More importantly, even if an individual who has influenza is considered disabled under the statute, health care professionals could avoid liability by showing that providing treatment would constitute a “direct threat” to the health care professional’s own health or safety.¹¹⁹ In *Bragdon v. Abbott*, the Supreme Court held that health care professionals cannot rely on the “direct-threat” defense by pointing to subjective fears of infection that are contradicted by objective evidence of safety.¹²⁰ During a pandemic, however, it is likely that whatever scientific evidence exists will either support health care professionals’ fears or be inconclusive.¹²¹ Given the general deference to medical judgment in disability-discrimination cases,¹²² it is unlikely that courts will allow recovery for a refusal to treat unless the health care professional’s fears of infection are contradicted by objective medical facts.¹²³

114. See Chai R. Feldblum, *Definition of Disability Under Federal Anti-Discrimination Law: What Happened? Why? And What Can We Do About It?*, 21 BERKELEY J. EMP. & LAB. L. 91, 93 (2000) (analyzing the definition of “disability” under the ADA).

115. 42 U.S.C. § 12102(2)(A). The plaintiff could also satisfy the definition of disability by showing that, even though she does not actually have an impairment that substantially limits a major life activity, she has a “record” of having such an impairment or is “regarded as” having such an impairment. *Id.* § 12102(2)(B)–(C).

116. 29 C.F.R. § 1630.2(i) (2008).

117. *Toyota Motor Mfg., Ry., Inc. v. Williams*, 534 U.S. 184, 198 (2002).

118. See Schwartz, *supra* note 110, at 670 (noting that a person infected with pandemic influenza “might be temporally limited because she would be able to experience a full recovery and hence she would not be covered under the ADA”).

119. 42 U.S.C. § 12182(b)(3) (2000).

120. *Bragdon v. Abbott*, 524 U.S. 624, 649 (1998).

121. See *supra* notes 42–48 and accompanying text (discussing health care professionals’ risks during pandemics).

122. See, e.g., *Lesley v. Chie*, 250 F.3d 47, 55 (1st Cir. 2001) (concluding that courts should defer to physicians’ medical justifications for treating disabled patients differently unless the physician’s decision is “devoid of any reasonable medical support”).

123. See Schwartz, *supra* note 110, at 673 (“*Bragdon* could be read to support the position that when there is a dearth of information regarding the potential risk to the healthcare provider and about the available treatment for the infected patient, the physician does not have a duty to treat.”).

D. STATE LICENSURE REQUIREMENTS

As discussed above, many professional organizations have taken the position that health care professionals have an ethical obligation to work during a pandemic.¹²⁴ However, professional associations in the United States are voluntary associations with no direct control over the practice of medicine.¹²⁵ While a few state licensing laws provide that violation of professional-ethics codes can constitute professional misconduct,¹²⁶ most state licensing laws do not contain such provisions. Thus, while physicians who fail to live up to professional organizations' ethics codes may be subject to peer disapproval, it is unlikely that such violations, in and of themselves, would be grounds for losing a license.

Under many states' licensing laws, however, abandonment of existing patients can lead to professional discipline.¹²⁷ Thus, professionals who fail to treat their existing patients during a pandemic could face disciplinary action. Unlike breach-of-contract actions, professional-misconduct proceedings do not require proof of actual damages.¹²⁸ Thus, a physician who refuses to treat her existing patients during a pandemic could be subject to professional discipline even if it is unlikely that the physician could have done anything to benefit the patients. However, abandonment is possible only if a professional-patient relationship has already been established. As such, in the absence of a pre-existing obligation to treat, health care professionals who refuse to work during a pandemic would probably not be subject to disciplinary action under state licensing codes.

124. See *supra* notes 67–68 and accompanying text.

125. See Katharine Van Tassel, *Hospital Peer Review Standards and Due Process: Moving from Tort Doctrine Toward Contract Principles Based on Clinical Practice Guidelines*, 36 SETON HALL L. REV. 1179, 1182 n.11 (2006) (“[M]embership in professional associations is not required for practice, and nonmembers cannot be disciplined.” (quoting John H. Colteaux, Note, *Hospital Staff Privileges: The Need for Legislation*, 17 STAN. L. REV. 900, 901 (1965))).

126. See, e.g., KY. REV. STAT. ANN. § 311.597(4) (West 2006) (defining “dishonorable, unethical, or unprofessional conduct” as including “any departure from, or failure to conform to the principles of medical ethics of the American Medical Association or the code of ethics of the American Osteopathic Association”); see also R.I. Dep’t of Health, Board of Medical Licensure and Discipline Homepage, <http://www.health.ri.gov/hsr/bmld/> (last visited Sept. 23, 2008) (“No single list or source can offer practicing physicians guidance in every conceivable circumstance. However, the Board relies upon the American Medical Association (AMA) code of ethics as the legal standard.”).

127. See, e.g., N.Y. COMP. CODES R. & REGS. tit. 8, § 29.2(a)(1) (2008) (defining “[u]nprofessional conduct” to include “abandoning or neglecting a patient . . . in need of immediate professional care, without making reasonable arrangements for the continuation of such care”).

128. See, e.g., *Moon Ho Huh v. N.Y. State Dep’t of Health*, 681 N.Y.S.2d 872, 873 (App. Div. 1998) (upholding the revocation of a physician’s license even though the physician’s actions “did not cause any actual harm to his patients”).

E. SUMMARY

As the discussion above makes clear, pre-existing employment or contractual relationships would obligate many health care professionals to work during a pandemic. With the possible exception of individuals who do not normally have direct patient-care responsibilities, health care professionals who work as employees could lose their jobs if they do not report to work during a pandemic. In addition, health care professionals who are subject to contractual obligations to treat patients could face breach-of-contract damages, civil fines under EMTALA, and professional discipline for patient abandonment. Thus, states that have not enacted laws authorizing mandatory orders to work during public-health emergencies will not face a situation in which health care professionals could walk away from their responsibilities without facing any repercussions. However, these repercussions would be grounded in health care professionals' voluntarily assumed prior commitments; individuals without such commitments would not be required to work based solely on their status as licensed professionals.

III. SPECIAL PENALTIES FOR HEALTH CARE PROFESSIONALS WHO REFUSE TO WORK DURING PANDEMICS

Growing attention to the twin threats of bioterrorism and pandemic influenza has led many states to review their public-health legislation. Many of these law-reform efforts have been based on the Model State Emergency Health Powers Act ("MSEHPA"), a proposal drafted by lawyers at the Center for Law and the Public's Health (a joint program of Johns Hopkins and Georgetown Universities) at the request of the Centers for Disease Control and Prevention.¹²⁹ Section 608 of the MSEHPA significantly expands the penalties health care professionals could face for refusing to work during a pandemic. That section gives public-health authorities the power to require health care professionals "to assist in the performance of vaccination, treatment, examination or testing of any individual as a condition of licensure, authorization, or the ability to continue to function as a health care provider in this State."¹³⁰ The term "health care provider" is broadly defined under the MSEHPA to include "any person or entity who provides health care services"¹³¹—not just doctors and nurses, but also dentists, laboratory technicians, and pharmacists.¹³²

129. MODEL STATE EMERGENCY HEALTH POWERS ACT (Ctr. for Law & the Public's Health, Georgetown & Johns Hopkins Univs., Discussion Draft 2001), available at <http://www.publichealthlaw.net/MSEHPA/MSEHPA2.pdf>.

130. *Id.* § 608(a).

131. *Id.* § 104(e).

132. *Id.*

The mandatory-work provisions of the MSEHPA have received surprisingly little attention in the academic literature.¹³³ Nonetheless, they have already had an impact on the development of state public-health statutes, including those in Maryland,¹³⁴ Delaware,¹³⁵ and South Carolina.¹³⁶ Some of these statutes go further than the MSEHPA by authorizing not only license revocations but also fines for and imprisonment of health care professionals who disobey an order to work.¹³⁷ These penalties would not be limited to professionals who fail to perform their existing job responsibilities. They could be imposed even on health care professionals who are not currently working or who are asked to perform tasks outside their normal job responsibilities.

A. *ARE SPECIAL PENALTIES CONSISTENT WITH HEALTH CARE
PROFESSIONALS' ETHICAL OBLIGATIONS?*

As noted above, most professional associations have concluded that health care professionals have an ethical obligation to work during infectious-disease outbreaks.¹³⁸ Many academic commentators have reached similar conclusions.¹³⁹ If this view is correct, statutes authorizing public-health officials to order health care professionals to work during a pandemic could be justified as mechanisms for encouraging professionals to live up to their ethical duties.¹⁴⁰ This Subpart therefore examines the primary arguments that have been made in support of the claim that health care professionals have an ethical obligation to work during pandemics. It concludes that these arguments do not provide a persuasive justification for

133. Other provisions of the MSEHPA have been more controversial, particularly those concerning isolation and quarantine. *See, e.g.*, George J. Annas, *Bioterrorism, Public Health, and Civil Liberties*, 346 NEW ENG. J. MED. 1337, 1340–41 (2002) (criticizing the MSEHPA's quarantine provisions).

134. *See* MD. CODE ANN., PUB. SAFETY § 14-3A-03(c) (LexisNexis Supp. 2007).

135. *See* DEL. CODE ANN. tit. 20, § 3140 (2005).

136. *See* S.C. CODE ANN. § 44-4-570 (Supp. 2007).

137. *See, e.g.*, MD. CODE ANN., PUB. SAFETY § 14-3A-08 (LexisNexis Supp. 2007). The original version of the MSEHPA provided that health care professionals who disobey orders to work would be guilty of a misdemeanor, but this provision was eliminated from the revised version of the Act. *See* Annas, *supra* note 133, at 1340.

138. *See supra* notes 67–68 and accompanying text.

139. *See infra* notes 141–46, 162–64, 177–78 and accompanying text.

140. This does not mean, of course, that everyone who believes that there is an ethical obligation for health care professionals to work during a pandemic would necessarily support these statutes. For example, Matthew Wynia argues that it would usually be preferable to rely on “soft” enforcement of professional duties, through penalties such as “loss of prestige or social and professional opprobrium.” Matthew K. Wynia, *Ethics and Public Health Emergencies: Encouraging Responsibility*, AM. J. BIOETHICS, Apr. 2007, at 1, 3. However, Wynia concludes that legal enforcement of professional duties might be appropriate “where health professional services are greatly needed, despite the risk.” *Id.*

the claim that simply *being* a health care professional—independent of one’s actual work responsibilities—creates an ethical duty to work.

1. Assumption of Risk

Some commentators argue that health care professionals have an inherent obligation to work during infectious-disease outbreaks because they “assume the risk” of exposure to infectious diseases when they voluntarily commit themselves to the healing profession.¹⁴¹ These commentators emphasize that working in health care is known to be dangerous. For example, one group of commentators points out that “any informed reading of the medical literature in the last 20 years has shown that infectious diseases remain ubiquitous and problematic.”¹⁴² Because of these dangers, they conclude, health care professionals “have consented to greater than average risk by their very choice of profession.”¹⁴³ One commentator compares physicians to firefighters, who “risk burns, even death, to fight blazes,” and lifeguards, who “risk injury to rescue drowning people.”¹⁴⁴ For all of these individuals, he concludes, risk-taking “is part of joining the profession and affirming its objective to help the needy.”¹⁴⁵

The assumption-of-risk argument makes sense as applied to health care professionals with certain types of job responsibilities. For example, as argued above, a physician who agrees to assume on-call responsibilities in a hospital emergency room commits to working under circumstances involving a foreseeable risk of exposure to contagious infections.¹⁴⁶ Enforcing this commitment is justified because, by affirmatively assuming this risk, the physician leads the hospital to rely on her presence. As a result, the hospital will forgo efforts to make alternative coverage arrangements.

141. See, e.g., Ruderman et al., *supra* note 68.

142. *Id.*

143. *Id.*

144. Ezekiel J. Emanuel, *Do Physicians Have an Obligation to Treat Patients with AIDS?*, 318 *NEW ENG. J. MED.* 1686, 1687 (1988).

145. *Id.* The analogy to firefighters is common. As discussed in a Canadian workgroup’s report:

Some believe that under dire circumstances, professionals should have minimal self-regard and pursue their duties at potential cost to their own lives. By analogy, firefighters do not have the freedom to choose whether or not they have to face a particularly bad fire, and police do not get to select which dark alleys they walk down.

PANDEMIC INFLUENZA WORKING GROUP, UNIV. OF TORONTO JOINT CTR. FOR BIOETHICS, *STAND ON GUARD FOR THEE: ETHICAL CONSIDERATIONS IN PREPAREDNESS PLANNING FOR PANDEMIC INFLUENZA* 10 (2005); see also Morin et al., *supra* note 67, at 419 (“[F]irefighters and police officers know of the threats they face and are obligated to provide services in spite of those risks; similarly, risks that are foreseeable from a medical perspective cannot be avoided by physicians.”).

146. See *supra* note 93 and accompanying text.

Thus, if the physician fails to follow through on the commitment, patients will be worse off than if the promise had never been made.

Many health care professionals, however, have never made any commitments to treat potentially infectious patients. Consider, for example, physicians who work in specialties like radiology, psychiatry, or infertility treatment. While such physicians are probably aware that infectious diseases remain “ubiquitous and problematic,” they choose to work in areas of health care in which those dangers are not relevant. Numerous health care professionals fall into this category, including not only those who work in clinical specialties not involving a significant risk of infection, but also those whose work does not involve any clinical duties, such as the medical director of a managed-care organization, a pharmacist involved in laboratory research, or a nurse who reviews malpractice claims for a law firm. Indeed, some licensed health care professionals are not currently working in any capacity, such as those who are taking time off from their profession to care for their children.

Even health care professionals who work in settings in which exposure to infectious diseases is a real possibility have not necessarily agreed to continue working in those settings under any and all circumstances. For example, many nurses work in hospitals as at-will employees. Unlike physicians who have assumed on-call responsibilities, or general practitioners who have ongoing physician–patient relationships, at-will employees are free to leave their jobs whenever they desire. While they may not be able to avoid exposure to infectious diseases if they want to keep their employment, they are under no obligation to remain in their jobs if they find the risks unacceptable. Indeed, the same is true for firefighters and lifeguards: while they cannot abandon their responsibilities in the midst of fighting a fire or saving a drowning swimmer, they are free to terminate their obligations prospectively by simply resigning from their jobs.¹⁴⁷

As such, the only way to make sense of the claim that all health care professionals have consented to assume a heightened risk of exposure to infection, regardless of their actual job responsibilities, would be to interpret the act of accepting a professional license as an implicit agreement to treat patients during infectious-disease outbreaks. The logic would be that accepting a professional license constitutes implicit consent to a package of obligations that are not individually negotiated.¹⁴⁸ For example, health care

147. Cf. Katherine A. Knopoff, *Can a Pregnant Woman Morally Refuse Fetal Surgery?*, 79 CAL. L. REV. 499, 529 (1991) (“In all special relationships but pregnancy, those in the dominant position can break off the special relationship whenever the dependent is not immediately in need: the shopkeeper can close or sell the shop, and the lifeguard can quit her job.”).

148. Cf. Daniels, *supra* note 60, at 43 (“It is not, after all, simply up to the individual entering a profession to tailor-make a contract that suits her wishes. The shape of the professional obligations to which an individual consents is determined over time through negotiation with society.”).

professionals must maintain patient confidentiality regardless of whether they specifically agree to such a duty when they take a particular job. It might be argued that a duty to treat infectious patients can similarly be viewed as part of the package of inherent professional commitments.

However, the reason that license holders are bound by a duty to preserve confidentiality is that this obligation is explicitly set forth in the standards for maintaining a professional license.¹⁴⁹ Applicants for licenses are therefore on notice that this is one of the duties they will be expected to follow. By contrast, a duty to work during infectious-disease outbreaks was not a part of licensing standards at the time most health care professionals applied for their licenses. They would therefore have no reason to assume that, by accepting a license, they were implicitly committing to treat infectious patients independent of the requirements of a particular job.

The fact that professional associations have recognized a duty to work during disasters does not change this analysis. As noted above, professional organizations in the United States are voluntary associations that have no authority to regulate medical practice.¹⁵⁰ While courts sometimes point to professional organizations' statements as evidence of standards of practice,¹⁵¹ courts do not generally rely on these statements as a sufficient basis, in and of themselves, for establishing enforceable duties.¹⁵² Many health care professionals in the United States are not even members of professional organizations; for example, the AMA represents only a quarter of physicians currently practicing in this country.¹⁵³ Even members of professional organizations do not agree to adhere to the organization's statements as a condition of maintaining their licenses. At most, they agree to abide by the organization's guidelines as a condition of remaining a member in good standing.

Indeed, while professional organizations sometimes phrase their positions in terms of "obligations," they often expressly disclaim any intent to turn their ethical positions into enforceable duties. For example, after

149. See, e.g., *Humphers v. First Interstate Bank of Or.*, 696 P.2d 527, 529 (Or. 1985) (observing that physicians' duty to maintain confidentiality derives from licensing requirements).

150. See *supra* note 125 and accompanying text.

151. See M. Gregg Bloche, *The Supreme Court and the Purposes of Medicine*, 354 NEW ENG. J. MED. 993, 994 (2006) (discussing the Supreme Court's use of AMA ethics statements).

152. Cf. *Mohanty v. St. John Heart Clinic, S.C.*, 866 N.E.2d 85, 94 (Ill. 2006) ("AMA Opinion 9.02, while informative, is not the equivalent of an Illinois statute or rule of professional conduct and, for that reason, does not provide a clear expression of the public policy of this state."). Some courts, however, rely on professional-ethics codes as "potential sources of public policy," with the conditions that the code provisions relied upon be "sufficiently concrete" and "primarily for the benefit of the public as opposed to the interests of the profession alone." *LoPresti v. Rutland Reg'l Health Servs., Inc.*, 865 A.2d 1102, 1112 (Vt. 2004) (quoting *Rocky Mountain Hosp. & Med. Serv. v. Mariani*, 916 P.2d 519, 525 (Colo. 1996)).

153. Schwartz, *supra* note 110, at 662.

September 11, 2001, the AMA adopted a “Contract with Humanity” that committed physicians to “[a]pply [their] knowledge and skills when needed, though doing so may put [them] at risk,”¹⁵⁴ but it expressly characterized the contract as a “symbolic statement” that should not be confused with “codes of ethics used in the adjudication of legal and ethical issues by professional boards and courts of law.”¹⁵⁵ Even in terms of nonbinding ethical guidance, the assumption that AMA statements represent “the definitive summary of ethical norms governing medicine” has been “rejected by the courts, by critical commentators, and even by many medical professionals.”¹⁵⁶

Finally, even if one were to take the position that, by joining the profession, health care professionals implicitly accept the obligations set forth by professional associations, existing professional organizations’ statements on infectious-disease outbreaks are recent developments. Most physicians working today, for example, joined the profession when the AMA was silent on physicians’ obligations during infectious-disease outbreaks. The fact that the AMA subsequently adopted a statement about physicians’ obligations during disasters provides no evidence of the risks these physicians thought they were assuming when they began their careers.

Some commentators argue that, for physicians, the oaths medical-school students take at graduation provide evidence of an agreement to work during infectious-disease outbreaks.¹⁵⁷ According to one commentator, these oaths represent “the graduate’s formal entry into the profession” and constitute a “public promise” that commits the graduate to an altruistic “effacement of . . . self interest[]” for the benefit of the sick.¹⁵⁸ However, the

154. AM. MED. ASS’N, DECLARATION OF PROFESSIONAL RESPONSIBILITY: MEDICINE’S SOCIAL CONTRACT WITH HUMANITY para. IV (2001), available at <http://www.ama-assn.org/ama/upload/mm/369/decoprofessional.pdf>.

155. COUNCIL ON ETHICAL & JUDICIAL AFFAIRS, AM. MED. ASS’N, A DECLARATION OF PROFESSIONAL RESPONSIBILITY, CEJA REPORT 5-I-01, at 1 (2001), available at <http://www.ama-assn.org/ama/upload/mm/369/declaration.pdf>. The fact that professional-ethics codes are not in themselves legally enforceable may actually be one of their strengths. See Criton A. Constantinides, *Professional Ethics Codes in Court: Redefining the Social Contract Between the Public and the Professions*, 25 GA. L. REV. 1327, 1346 (1991) (“[I]f courts were to adopt codes as law, professions might simply relax their standards to limit exposure of their members.”).

156. Freedman, *supra* note 61, at 21 (quoting Robert M. Veatch, *Challenging the Power of Codes*, HASTINGS CENTER REP., Oct. 1986, at 14, 14).

157. See, e.g., Rosamond Rhodes, Commentary, *The Professional Obligation of Physicians in Times of Hazard and Need*, 15 CAMBRIDGE Q. HEALTHCARE ETHICS 424, 424–25 (2006) (relying in part on physicians’ oaths to conclude that physicians’ obligation to respond to disasters “should be straightforward and incontrovertible”).

158. Edmund D. Pellegrino, *Altruism, Self-Interest, and Medical Ethics*, 258 JAMA 1939, 1939 (1987). Pellegrino made these arguments in response to physicians who were unwilling to treat HIV-positive patients, but his rationale applies to infectious diseases generally. See *id.* (“The physician is no more free to flee from danger in performance of his or her duties than the fireman, the policeman, or the soldier.”).

oaths that physicians currently take at medical-school graduations¹⁵⁹ do not contain any statements that even hint at an obligation to work during infectious-disease outbreaks. The only statements that could even plausibly be construed as a commitment to act altruistically are vague pronouncements like “I solemnly pledge myself to consecrate my life to the service of humanity,”¹⁶⁰ or “I will remember that I remain a member of society, with special obligations to all my fellow human beings.”¹⁶¹ An individual who makes these commitments would have no reason to believe that she was agreeing to treat patients during an infectious-disease outbreak even if her job does not require it.

Of course, in states that have enacted statutes modeled on Section 608 of the MSEHPA, individuals who join the health care profession are now on notice that they could be required to work during infectious-disease outbreaks, given that the authority to impose such a requirement is now explicitly set forth in state legislation. In these states, it is now more plausible to say that the decision to accept a professional license constitutes an implicit agreement to work during all types of public-health emergencies, including pandemics. However, the existence of these statutes does nothing to change the assumption-of-risk argument for health care professionals who obtained their licenses before the statutes were enacted. Moreover, the fact that these statutes put health care professionals on notice of a new legal requirement does not in itself establish that the requirement is justified. If the purpose of the assumption-of-risk argument is to show that the statutes are grounded in health care professionals’ inherent ethical obligations, the basis for the assumption of risk cannot be simply the existence of the statutes themselves.

159. Medical schools use a variety of different oaths, some of which are written by the students themselves. See Erich H. Loewy, *Oaths for Physicians—Necessary Protection or Elaborate Hoax?*, MEDSCAPE GEN. MED., Jan. 10, 2007, <http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=1925028>. Some schools use variants of the Hippocratic Oath, but the original Hippocratic Oath has fallen out of favor. See Barbara A. Gabriel, *A Hippocratic Oath for Our Time*, AAMC REP., Sept. 2001, available at <http://www.aamc.org/newsroom/reporter/sept2001/hippocraticoath.htm> (noting that, in 1993, only one medical school used the exact wording of the Hippocratic Oath). This is not surprising, as the original Oath required physicians to make many promises that would no longer be considered acceptable, including promises to teach medicine to the children of their teachers without accepting a fee, to share their money with their teachers if the teachers needed it, and to refrain from performing surgery or abortions. See generally Lisa R. Hasday, *The Hippocratic Oath as Literary Text: A Dialogue Between Law and Medicine*, 2 YALE J. HEALTH POL’Y L. & ETHICS 299 (2002) (discussing the evolution of the Hippocratic Oath).

160. Ralph Crawshaw & Carol Link, Commentary, *Evolution of Form and Circumstance in Medical Oaths*, 164 W.J. MED. 452, 454 (1996) (quoting the World Medical Association’s Declaration of Geneva).

161. Association of American Physicians and Surgeons, Various Physicians Oaths, <http://www.aapsonline.org/ethics/oaths.htm#lasagna> (last visited Sept. 26, 2008).

2. Social Contract

Another argument that has been used to support the claim that health care professionals have an obligation to work during a pandemic is based on the idea of a “social contract.” The claim, which is usually limited to physicians, is that “society grants the medical profession[] . . . special social status and certain privileges” in exchange for the profession’s implicit agreement “to promote society’s health.”¹⁶² The privileges include, among other things, high status, monopoly protection, and deference to professional self-regulation.¹⁶³

For some commentators, the special benefits that society grants the medical profession are relevant because they demonstrate the fairness of requiring physicians to work during infectious-disease outbreaks.¹⁶⁴ In this view, society is not asking physicians to make uncompensated sacrifices; rather, it is imposing a reasonable quid pro quo for the special benefits that physicians already enjoy. The problem with this argument is that, even if such an arrangement might seem fair to an outside observer, an essential element of a contract is a voluntary agreement. As such, the terms of physicians’ contract with society must bear some relationship to the obligations that physicians actually think they are assuming when they join the medical profession.¹⁶⁵ As discussed above, there is no evidence that most physicians believed that, by acquiring a medical license, they were agreeing to work during infectious-disease outbreaks regardless of the requirements of their actual jobs.¹⁶⁶

That is not to say that physicians do not incur any social obligations as a result of the benefits that society extends the medical profession. For example, in light of the public subsidies given for medical education,¹⁶⁷ it is not unreasonable to claim that society has a right to share in the benefits of physicians’ knowledge and training.¹⁶⁸ However, even assuming that

162. Russell L. Gruen et al., *Physician-Citizens—Public Roles and Professional Obligations*, 291 JAMA 94, 95 (2004).

163. See *id.* (discussing several benefits that health professionals receive for their commitment to societal health).

164. See, e.g., Ruderman et al., *supra* note 68 (suggesting that “a social contract” between health care professionals and society gives the public “a reasonable and legitimate expectation” that health care professionals “will respond in an infectious disease emergency”).

165. Cf. Daniels, *supra* note 60, at 41 (arguing that even if a duty to treat could be justified as consistent with principles of justice, it would still be necessary to show that physicians actively accepted such a duty).

166. See *supra* Part III.A.1 (analyzing assumption-of-risk arguments).

167. See Christopher J. Conover, *Distributional Considerations in the Overregulation of Health Professionals, Health Facilities, and Health Plans*, 69 LAW & CONTEMP. PROBS. 181, 184, Autumn 2006, at 181, 184 (discussing Medicare funding of graduate medical education).

168. See Pellegrino, *supra* note 158, at 1939 (arguing that, in light of public support for medical education, physicians’ knowledge “is not individually owned and ought not be used primarily for personal gain, prestige, or power”).

physicians have a general obligation to pay back to society, that does not mean that they must necessarily do so by taking risks with their lives.

Indeed, there are many other ways that physicians can and do fulfill their social obligations. For example, some physicians work in medically underserved communities or provide free care to indigent patients.¹⁶⁹ Given that the societal benefits physicians enjoy are primarily economic in nature, physicians could reasonably argue that any obligations they owe to society should be limited to these types of financial sacrifices, as opposed to taking risks with their own health.

Some commentators have attempted to link the types of special privileges society gives the medical profession to an obligation to treat patients during infectious-disease outbreaks. For example, one commentator argues that granting physicians monopoly protection would make no sense unless it was accompanied by a commitment to work during infectious-disease outbreaks. She asks, “Why would society grant exclusive scope of practice in relation to an essential human service to a professional group not prepared to guarantee provision of that service in an emergency?”¹⁷⁰

This argument, however, implies that society had a choice among multiple professional groups capable of providing medical services and, therefore, that it was in a position to extract concessions from the group to which it chose to award monopoly protection. But society did not give the medical profession an exclusive scope of practice because physicians offered a better package of benefits than some competing professional body. Rather, it did so because physicians are the only ones capable of providing competent medical treatment.¹⁷¹ Even if physicians had explicitly refused to guarantee the provision of care during infectious-disease outbreaks, society would probably still have given them an exclusive scope of practice in order to protect the public from charlatans.

Another variation of the social-contract argument emphasizes that physicians enjoy special privileges partly *because of* society’s belief that physicians will treat patients during infectious-disease outbreaks. For example, some commentators maintain that the public’s belief that doctors have an “obligation to treat all sick people” creates “social expectations” about physicians’ behavior that stimulate “public respect, admiration, and

169. See, e.g., Stephen L. Isaacs & Paul Jellinek, *Is There a (Volunteer) Doctor in the House? Free Clinics and Volunteer Physician Referral Networks in the United States*, 26 HEALTH AFF. 871, 871 (2007) (discussing the large number of private physicians who work with indigent patients).

170. Lynette Reid, *Diminishing Returns? Risk and the Duty to Care in the SARS Epidemic*, 19 BIOETHICS 348, 353 (2005).

171. See Timothy Stoltzfus Jost, *Oversight of the Quality of Medical Care: Regulation, Management, or the Market?*, 37 ARIZ. L. REV. 825, 827 (1995) (explaining that one of the original justifications for licensing health care professionals was that it would assure “the competence of practitioners by confirming that they ‘possessed the requisite qualification’” (quoting *Dent v. West Virginia*, 129 U.S. 114, 123 (1889))).

prestige for the medical profession.”¹⁷² They argue that these social expectations themselves “form[] an important component of the medical profession’s social contract.”¹⁷³

It may be true that physicians enjoy high status partly because the public expects physicians to be altruistic. However, all this means is that, if physicians refuse to work during a pandemic, the medical profession’s status may suffer. Because there is no evidence that the public’s expectation of care from physicians during infectious-disease outbreaks stems from physicians’ own actions or promises,¹⁷⁴ those expectations do not provide a basis for recognizing an enforceable duty to treat.

Ultimately, the social-contact argument adds little, if anything, to the assumption-of-risk theory. Moreover, the argument sends a disturbing message about the nature of physicians’ relationship with the rest of society. It implies that physicians owe a debt to society because their ordinary level of service is insufficient to justify their privileged social status—or, put another way, that physicians are actually a drain on society because they extract greater social benefits than their existing contributions warrant. The message is that only by risking their lives during infectious-disease outbreaks can physicians begin to repay society for their exalted social status. In fact, there are many other segments of society that enjoy far greater social advantages, while providing far fewer societal benefits, than do physicians.¹⁷⁵ For example, hedge-fund managers earn far more income than the average primary-care physician; moreover, society subsidizes hedge-fund managers’ income by giving it preferential tax treatment.¹⁷⁶ Yet no one is demanding that hedge-fund managers incur potentially life-threatening risks to compensate for these special advantages. The very implausibility of this suggestion demonstrates that, as a society, we simply do not believe that receiving extra social benefits creates an obligation to assume disproportionate risks.

172. Huber & Wynia, *supra* note 49, at W7.

173. *Id.*

174. Indeed, the commentators quoted in the text rely on survey data about public attitudes in 1991, which was well after the AMA had revised its Code of Medical Ethics to eliminate any references to a duty to work during infectious-disease outbreaks. *See id.*

175. Even in terms of social status, physicians are no longer as special as they used to be. *See* Alex Williams, *The Falling-Down Professions*, N.Y. TIMES, Jan. 6, 2008, § 9, at 1 (suggesting that the pressures of managed care, increased public skepticism about the authority of physicians, and the growing prestige of Internet entrepreneurs and investment bankers have led many physicians to feel a significant loss of social status).

176. *See* Victor Fleischer, *Two and Twenty: Taxing Partnership Profits in Private Equity Funds*, 83 N.Y.U. L. REV. 1, 3–4 (2008) (explaining that hedge-fund managers are able to structure their compensation so that most of their income is treated as capital gain, which is taxed at a lower rate than ordinary income).

3. Special Skills

A third argument for recognizing an obligation to treat patients during a pandemic is grounded in the fact that health care professionals have knowledge and special skills that “enable [them] to help more effectively, and in greater safety, than the average citizen.”¹⁷⁷ Some commentators argue that because “the ability of physicians and health care professionals to provide care is greater than that of the public,” it is reasonable for society to expect them to assume greater risks.¹⁷⁸

In general, however, having special skills does not create an obligation to use them. For example, a physician who is the only health care provider in an isolated rural community is free to move elsewhere. The fact that the community will be worse off without the physician does not create an obligation for the physician to stay.

One possible difference between the rural physician and a health care professional who is needed during a pandemic is the nature—in terms of both severity and urgency—of the danger; during a pandemic, health care professionals’ refusal to use their skills will have immediate life-or-death consequences. While American law does not recognize a general legal obligation to rescue persons in dangerous situations,¹⁷⁹ most people would probably agree that, as an ethical matter, a person who is uniquely capable of saving someone’s life has a *prima facie* duty to act.¹⁸⁰ For example, few would deny that an individual who spots an accident victim on a deserted highway should phone for an ambulance, even though doing so is not legally required. Given that a person’s life is at stake and the burdens of acting would be minimal, it is hard to come up with an ethical justification for failing to act.

However, the analysis becomes different when rescue is possible only by assuming significant danger. In these situations, rescue is generally seen as supererogatory, or morally optional, behavior.¹⁸¹ For example, living persons who donate a kidney or bone marrow are considered to be acting heroically—i.e., they are seen as going beyond the normal call of duty.

177. Chalmers C. Clark, *In Harm’s Way: Service in the Face of SARS*, HASTINGS CENTER REP., July–Aug. 2003, at inside back cover.

178. Ruderman et al., *supra* note 68.

179. See David A. Hyman, *Rescue Without Law: An Empirical Perspective on the Duty to Rescue*, 84 TEX. L. REV. 653, 655 (2006).

180. See *id.* (noting that the no-duty-to-rescue rule is “distinctly unpopular”).

181. See, e.g., Melvin A. Eisenberg, *The Duty to Rescue in Contract Law*, 71 FORDHAM L. REV. 647, 677–78 (2002) (setting forth the “moral obligation” to rescue as a duty “to take action to save a victim from physical peril if there is no significant risk or other cost to the actor and failure to take the action would probably result in death or substantial injury to the victim”). In countries that recognize a legal duty to rescue, the duty is limited to situations that do not expose the rescuer to significant risk. See, e.g., Edward A. Tomlinson, *The French Experience with Duty to Rescue: A Dubious Case for Criminal Enforcement*, 20 N.Y.L. SCH. J. INT’L & COMP. L. 451, 452 (2000).

Indeed, we go to great lengths to ensure that living organ donors act out of genuine altruistic desires. Thus, the process of obtaining informed consent to live organ donation is unusually elaborate in order to detect any nonaltruistic motivations that may be influencing the decision.¹⁸² If someone does not want to donate an organ to a critically ill relative, doctors may offer a medical excuse, such as tissue incompatibility, that allows the person to back out of the donation without being made to feel that they have done something wrong.¹⁸³

It might be argued that ordinary expectations about personal sacrifice are inapplicable during large-scale emergencies. Thus, one might claim that, when society's very existence is in danger, as it would be during a serious pandemic, those in a position to help have an obligation to do so even at substantial personal risk. Yet, while this might seem like a reasonable ethical position to some people, there is no evidence that it reflects a widely shared belief in contemporary American society. If anything, the evidence is to the contrary, given our unwillingness to reinstate a military draft even though the country is currently at war.¹⁸⁴

Moreover, even assuming there is an ethical obligation to take greater-than-usual risks during national emergencies, there would be no reason to limit this obligation to people who happen to work in the health care professions. Numerous categories of workers outside of health care will be essential during a pandemic, ranging from police and firefighters to water and electric workers.¹⁸⁵ Some of these people will be indispensable because, like health care professionals, they have unique skills that will make it difficult to find replacement workers. Others may simply be the most readily available people capable of performing critical tasks, such as transporting essential supplies. If the ethical rationale for forcing people to work during a pandemic is that they are indispensable to the response effort, the law should not single out health care professionals for special punitive sanctions that do not apply to equally indispensable workers in other sectors.

182. See, e.g., Authors for the Live Organ Donor Consensus Group, *Consensus Statement on the Live Organ Donor*, 284 JAMA 2919, 2920 (2000) (recommending, among other measures, the appointment of "independent advocates" for donors in order to help "verify the donor's freedom from coercion").

183. See *id.* at 2921 (arguing that "if the potential donor anticipates being ostracized from the family by saying 'no' to the recipient, the transplant team could assist the potential donor in developing an appropriate medical disclaimer, enabling the potential donor to decline gracefully," but emphasizing that they "should not falsify donor medical information to the recipient in an attempt to provide the donor with a reason to decline").

184. See Bob Herbert, Op-Ed., *While Iraq Burns*, N.Y. TIMES, Nov. 27, 2006, at A23 ("[I]t has long been clear that there is zero sentiment in favor of a draft in the U.S.").

185. See U.S. DEP'T OF HEALTH & HUMAN SERVS. & U.S. DEP'T OF HOMELAND SEC., GUIDANCE ON ALLOCATING AND TARGETING PANDEMIC INFLUENZA VACCINE 6 tbl.1 (2008) [hereinafter DHHS & DHS GUIDANCE], available at <http://www.pandemicflu.gov/vaccine/allocationguidance.pdf> (recommending the prioritization of such workers for pandemic influenza vaccines).

B. ARE SPECIAL PENALTIES CONSTITUTIONAL?

The previous Subpart argued that laws requiring health care professionals to work during pandemics regardless of their specific job obligations cannot be justified by health care professionals' ethical obligations. Whether states have the constitutional authority to enact these laws is, of course, a separate question. This Subpart argues that, despite the ethical concerns discussed above, wholesale constitutional challenges to these laws are unlikely to be successful. However, certain applications of the statutes could raise significant constitutional concerns.

1. Involuntary Servitude

Laws requiring health care professionals to treat patients during infectious-disease outbreaks could be challenged as a violation of the Thirteenth Amendment's prohibition of involuntary servitude. Under the Thirteenth Amendment, "[n]either slavery nor involuntary servitude, except as a punishment for crime whereof the party shall have been duly convicted, shall exist within the United States."¹⁸⁶ While statutorily mandated treatment of patients during a pandemic is obviously quite different from the type of master-servant relationships that existed before the adoption of the Thirteenth Amendment, courts have made clear that the Amendment's application is not limited to the traditional forms of slavery that existed in the pre-Civil War South.¹⁸⁷

The primary barrier to a successful Thirteenth Amendment challenge to statutes requiring health care professionals to work during infectious-disease outbreaks is case law upholding the government's authority to compel individuals to perform mandatory public service. In *Butler v. Perry*, for example, the Supreme Court rejected a Thirteenth Amendment challenge to a Florida statute that required men to work without pay on roads and bridges for six days each year.¹⁸⁸ In upholding the law, the Court held that the Thirteenth Amendment "was not intended to interdict enforcement of those duties which individuals owe to the State, such as services in the army, militia, on the jury, etc."¹⁸⁹ Similarly, in the *Selective Draft Law Cases*, the Court flatly rejected the suggestion that the Thirteenth Amendment prohibits "the exaction by government from the citizen of the

186. U.S. CONST. amend. XIII, § 1.

187. See Michael H. LeRoy, *Compulsory Labor in a National Emergency: Public Service or Involuntary Servitude? The Case of Crippled Ports*, 28 BERKELEY J. EMP. & LAB. L. 331, 356-57 (2007) (discussing cases "broadening the original application of the term 'involuntary servitude' to modern situations").

188. *Butler v. Perry*, 240 U.S. 328, 332-33 (1916).

189. *Id.* at 333.

performance of his supreme and noble duty of contributing to the defense of the rights and honor of the nation, as the result of a war.”¹⁹⁰

However, these cases do not mean that public-service requirements can never violate the Thirteenth Amendment’s prohibition of involuntary servitude. In both *Butler* and the *Selective Draft Law Cases*, the challenged requirements were considered obligations of citizenship before the enactment of the Thirteenth Amendment. Florida’s mandatory-road-work law, for example, was grounded in the ancient Roman doctrine of *trinoda necessitas*, under which the state “has inherent power to require every able-bodied man within its jurisdiction to labor for a reasonable time on public roads near his residence without direct compensation.”¹⁹¹ Mandatory military service also has a long pedigree.¹⁹² The fact that the Thirteenth Amendment does not preclude the government from requiring individuals to perform services that have historically been considered obligations of citizenship does not necessarily mean that the government can impose new work obligations that lack this historical support.

In evaluating the constitutionality of mandatory public-service programs that are not grounded in historically rooted civic obligations, courts have relied on a “contextual approach”¹⁹³ that focuses on “the nature and amount of the work demanded, and the purpose for which it is required.”¹⁹⁴ For example, in rejecting a Thirteenth Amendment challenge to a law requiring students of public high schools to perform community service as a condition of graduation, the Second Circuit emphasized that the requirement was limited in time, “hardly onerous,” and designed to further the students’ education.¹⁹⁵ The fact that students had alternatives to participating in the program—for example, they could attend private school—was also important.¹⁹⁶ Indeed, the Third Circuit has suggested that the concept of involuntary servitude can never apply as long as there are “alternatives to performing the labor,” even if those alternatives “may not be

190. *Selective Draft Law Cases*, 245 U.S. 366, 390 (1918).

191. *Butler*, 240 U.S. at 330.

192. The United States did not adopt a federal draft until the Civil War. See David P. Currie, *The Civil War Congress*, 73 U. CHI. L. REV. 1131, 1196 (2006) (“Congress in March 1863 adopted a statute conscripting individuals into the armed forces for the first time in its history.”). However, service in the militia had been compulsory in most states since colonial times. See Alan Hirsch, *The Militia Clauses of the Constitution and the National Guard*, 56 U. CIN. L. REV. 919, 923 (1988) (“In most of the colonies, militia service was compulsory for able-bodied males between eighteen and fifty.”).

193. *Immediato v. Rye Neck Sch. Dist.*, 73 F.3d 454, 459 (2d Cir. 1996) (quoting *Steirer v. Bethlehem Area Sch. Dist.*, 987 F.2d 989, 1000 (3d Cir. 1993)).

194. *Id.* (citing *Jobson v. Henne*, 355 F.2d 129, 132 (2d Cir. 1966)).

195. *Id.* at 460.

196. See *id.* (“[Students] may avoid the program and its penalties by attending private school, transferring to another public high school, or studying at home to achieve a high school equivalency certificate. While these choices may be economically or psychologically painful, choices they are, nonetheless.”).

appealing.”¹⁹⁷ For example, it observed that pro bono requirements for lawyers do not constitute involuntary servitude because “a lawyer can choose not to practice law.”¹⁹⁸

Laws requiring health care professionals to work during a pandemic are distinguishable from the type of requirements that have been upheld under this contextual analysis. First, these laws would require health care professionals to engage in activities that involve life-threatening dangers. Other than mandatory military service, which has clear historical foundations, courts have never upheld compulsory-service statutes “when individuals face threats to health and safety.”¹⁹⁹ Second, while the penalties under the MSEHPA are limited to revoking a health care professional’s license, some state laws also provide that a health care professional who disobeys an order to work could be fined or imprisoned.²⁰⁰ Because the laws do not give health care professionals the option of giving up their licenses instead of submitting to these penalties, health care professionals who want to avoid criminal punishment would have no “alternatives to performing the labor.”²⁰¹

That being said, it is hard to imagine that courts would hold that the Thirteenth Amendment prevents states from imposing any emergency-service requirements on health care professionals. Limited service requirements during emergencies simply do not seem to “approximate slavery in its severity and intensity.”²⁰² Yet, particular applications of mandatory-emergency-service statutes might be vulnerable to Thirteenth Amendment challenges. For example, an unemployed nurse who is given the choice between spending weeks treating patients on the front lines of a pandemic or going to prison might plausibly claim that such a choice involves the sort of compelled labor that the Thirteenth Amendment was designed to prevent.

2. Due Process

Health care professionals have a property interest in their professional licenses,²⁰³ and they obviously have a liberty interest in being free from imprisonment. Thus, statutes that authorize deprivations of these interests as penalties for refusing to work during a pandemic must comply with the

197. *Steirer*, 987 F.2d at 1000.

198. *Id.* at 999–1000 (citing *United States v. 30.64 Acres of Land*, 795 F.2d 796, 800–01 (9th Cir. 1986)).

199. LeRoy, *supra* note 187, at 364.

200. *See supra* note 137 and accompanying text.

201. *Steirer*, 987 F.2d at 1000.

202. Rodney A. Smolla, *The Constitutionality of Mandatory Public School Community Service Programs*, 62 LAW & CONTEMP. PROBS. 113, 120, Autumn 1999, at 113, 120.

203. *See Schwartz, supra* note 110, at 688 (citing *Devous v. Wyo. State Bd. of Med. Exam’rs*, 845 P.2d 408, 415 (Wyo. 1993)).

requirements of the Due Process Clause.²⁰⁴ Health care professionals who are subjected to penalties for refusing to work during a pandemic could raise two types of due process challenges. First, they could challenge the underlying legislative decision to authorize the penalties. Second, they could challenge the application of the penalties in a particular case.

Broad due process challenges to statutes that authorize public-health officials to order health care professionals to work during a pandemic are unlikely to be successful. Such statutes would be analyzed under the “rational basis” standard, as neither the property interest in a license²⁰⁵ nor the liberty interest in being free from imprisonment²⁰⁶ is considered a fundamental right. While this Article questions the ethical justification for requiring health care professionals to work during a pandemic regardless of their pre-existing work obligations, it is hard to characterize such requirements as completely irrational. A legislature could rationally believe that authorizing penalties for refusing to work would increase the supply of medical services in emergency situations.

Even if the statutes are generally valid, however, a health care professional could raise substantive or procedural due process challenges to the manner in which the statutes are implemented. A substantive due process challenge would go to the justification for the government’s decision to take action against a particular health care professional. Such challenges would be extremely difficult, as the plaintiff would have to show that the decision to take action against her was so unfounded or biased that it “shocks the conscience.”²⁰⁷ Nonetheless, the ability to challenge public-health officials’ decisions could offer “an important check” on potential abuses of authority during emergency situations.²⁰⁸ Health care professionals would also have procedural due process rights to notice and an opportunity to challenge any allegations of failing to work.²⁰⁹

204. U.S. CONST. amend. XIV, § 1 (“No State shall . . . deprive any person of life, liberty, or property, without due process of law . . .”).

205. See, e.g., *Meier v. Anderson*, 692 F. Supp. 546, 549 (E.D. Pa. 1988) (“The plaintiffs err . . . in classifying the right to practice one’s chosen profession as a fundamental right.”), *aff’d*, 869 F.2d 590 (3d Cir. 1989); Schwartz, *supra* note 110, at 688 (“A physician’s property interest in her medical license is not . . . a fundamental right.”).

206. See Sherry F. Colb, *Freedom from Incarceration: Why Is This Right Different from All Other Rights?*, 69 N.Y.U. L. REV. 781, 785 (1994) (criticizing the Supreme Court for failing to recognize the right to physical liberty as a fundamental right).

207. *Tonkovich v. Kan. Bd. of Regents*, 159 F.3d 504, 528 (10th Cir. 1998).

208. See Schwartz, *supra* note 110, at 689–90 (suggesting that “there would be a heightened risk that the governor, subject to intense pressures from multiple parties, including alarmed constituents and federal officials trying to contain an epidemic, might act in an arbitrary or irrational fashion,” and concluding that “even a minimal level of scrutiny as applied by the courts provides an important check on the executive’s power”).

209. See *id.* at 690 (criticizing the MSEHPA for failing “to recognize the need for procedural due process in the context of physicians’ rights”).

IV. ALTERNATIVE APPROACHES

The potential shortage of health care professionals during a pandemic is a serious problem. However, compelling all health care professionals to work, even if they are not subject to any pre-existing treatment obligations, is not the only solution. For example, rather than singling out health care professionals for special punishments, policymakers can provide positive incentives for all individuals—including, but not limited to, health care professionals—to contribute necessary services during a pandemic. Policymakers can also remove disincentives to volunteering by supporting methods to reduce and respond to risk, as well as by addressing volunteers' concerns about civil and criminal liability. Professional organizations and health care institutions can contribute to this effort by encouraging the development of social norms that support volunteerism. In addition to increasing the supply of workers during a pandemic, promoting volunteerism is likely to result in a more motivated workforce.²¹⁰ Moreover, all things being equal, most people would probably prefer being cared for by someone who has chosen to work rather than one whose sole goal is to avoid being punished.

A. POSITIVE INCENTIVES

One alternative to a punitive approach would be to create mechanisms that recognize and reward individuals who agree to work during a pandemic. During the SARS crisis, for example, health care workers in many countries received significant financial incentives to treat infectious patients. In Vietnam, these incentives amounted to five times workers' normal salaries.²¹¹ Other types of rewards could include letters or phone calls of thanks from government officials or popular celebrities, public recognition ceremonies, or awards by private organizations.²¹²

The use of financial incentives should be approached with caution. While basic economic theory might suggest that paying people more will increase their willingness to provide services, this assumption does not necessarily hold true for services that individuals would otherwise be willing to provide for altruistic reasons. On the contrary, there is evidence that paying people for "doing good" can backfire by depriving them of "the boost

210. Cf. Eric Lichtblau, *Flurry of Calls About Draft, and a Day of Denials*, N.Y. TIMES, Dec. 23, 2006, at A14 (noting that senior military officers oppose a return to the draft because draftees "are not as motivated as volunteers").

211. See ROTHSTEIN ET AL., *supra* note 76, at 133 (noting that hospitals in Toronto doubled the salaries of nurses who treated SARS patients and that physicians and nurses in Taiwan received "danger pay" of \$300 and \$150 per day, respectively).

212. For example, the Carnegie Hero Fund gives medals to "persons who perform acts of heroism in civilian life." Carnegie Hero Fund Homepage, <http://www.carnegiehero.org> (last visited Sept. 24, 2008).

in self-esteem associated with succoring others out of apparent goodwill.”²¹³ Studies show that even small rewards lead people “to infer that they behaved well in order to obtain the reward,” and that this inference “actually undermines pre-existing interest in the activity and leads to less participation by choice on future occasions.”²¹⁴ One example of this phenomenon is that paying people for blood has been shown to decrease their willingness to donate. As the authors of *Freakonomics* observe, “[t]he stipend turned a noble act of charity into a painful way to make a few dollars, and it wasn’t worth it.”²¹⁵

This does not mean that positive incentives can never increase individuals’ willingness to engage in socially desirable activities. Rewards that lead individuals to attribute their behavior to internally driven motivations may increase, rather than diminish, individuals’ altruistic tendencies. For example, in a series of studies, children who were paid money for sharing were likely to attribute their actions “to external causes and not to their own personal nature,” but when the reward consisted of “social praise,” they were more likely to see their sharing as a sign of their own internal goodness.²¹⁶ As a result, the latter group of children “were more likely to share with others when an opportunity later presented itself.”²¹⁷ This suggests that symbolic rewards that stress the nobility of the act of volunteering may strengthen individuals’ desire to act altruistically.²¹⁸

213. Michael B. Dorff, *Softening Pharaoh’s Heart: Harnessing Altruistic Theory and Behavioral Law and Economics to Rein in Executive Salaries*, 51 *BUFF. L. REV.* 811, 877 (2003).

214. Reed Elizabeth Loder, *Tending the Generous Heart: Mandatory Pro Bono and Moral Development*, 14 *GEO. J. LEGAL ETHICS* 459, 472–73 (2001).

215. STEVEN D. LEVITT & STEPHEN J. DUBNER, *FREAKONOMICS: A ROGUE ECONOMIST EXPLORES THE HIDDEN SIDE OF EVERYTHING* 24 (2005). The impact of payment on individuals’ willingness to donate organs has long been a matter of debate. See, e.g., Steve P. Calandrillo, *Cash for Kidneys? Utilizing Incentives to End America’s Organ Shortage*, 13 *GEO. MASON L. REV.* 69, 92 n.118 (2004) (summarizing competing views on the question); Adam J. Kolber, *A Matter of Priority: Transplanting Organs Preferentially to Registered Donors*, 55 *RUTGERS L. REV.* 671, 674 & n.6 (2003) (discussing a survey in which “[o]nly 12% [of respondents] said that financial incentives would make them more likely to donate,” while “5% said that financial incentives would make them less likely to donate,” but noting that the reliability of the survey is questionable because individuals were not told the size of the payments).

216. Mark S. Sobus, *Mandating Community Service: Psychological Implications of Requiring Prosocial Behavior*, 19 *LAW & PSYCHOL. REV.* 153, 169 (1995).

217. *Id.* at 170.

218. See *id.* (“The key point in all of this research is that no matter how the prosocial behavior is elicited, the goal is to get the person being controlled to make attributions that are internal and positive.”). David Hyman has argued that individuals who rescue others in the absence of a legal duty are generally motivated by “hard-wired altruism” and that “ex post awards or public recognition . . . are unlikely to be material factors in whether a rescue occurs.” Hyman, *supra* note 179, at 704. However, Hyman’s focus was on spontaneous, one-time rescues, such as diving into a pool to rescue a drowning swimmer. Positive incentives may be more effective in situations where individuals are asked to make a conscious decision to engage in risky altruistic behavior over a sustained period of time.

Financial incentives also may be effective in some situations.²¹⁹ If the risks of working during a pandemic are significant, there simply may not be enough people who will want to work because of altruistic motivations. Under these circumstances, the danger of interfering with altruistic volunteerism might be outweighed by the potential for financial incentives to encourage individuals to work for less idealistic reasons.²²⁰ It may make sense, therefore, to consider financial incentives as a backup strategy for later stages of a pandemic, in case altruism is no longer producing a sufficient number of volunteers.²²¹

Regardless of their potential effectiveness, a concern with offering financial rewards for working during a pandemic is that poorer people will be more influenced by economic incentives than wealthier people. As a result, the volunteer health care professional workforce may be disproportionately made up of members of socially disadvantaged groups. In fact, this is one of the primary criticisms of the volunteer military—that an all-volunteer force results in a system in which the burdens of service are not spread equally throughout society.²²²

However, the danger of exploiting disadvantaged populations is somewhat reduced with health care professionals because these are skilled workers with a baseline of economic security. Moreover, one of the primary concerns raised by the socioeconomic makeup of the military is that, if the children of the rich and powerful are not represented in the military, those in a position to influence policy will be insufficiently cautious about starting or continuing a war.²²³ In other words, with the military, the equality

219. The AMA's Council on Ethical and Judicial Affairs has endorsed the use of financial incentives to encourage physicians to work in disaster situations. See Morin et al., *supra* note 67, at 420 (suggesting that "volunteer teams could be offered due compensation for their training, as well as their assumption of risks").

220. As one commentator points out, the potential for rewards to discourage volunteers who would otherwise be motivated by personal satisfaction "applies only to people who already have intrinsic interest" in an activity. Loder, *supra* note 215, at 474.

221. Some commentators have suggested that financial incentives could be used to create a reserve corps of specially designated physicians—a "Medical National Guard"—"who would be paid to periodically participate in training programs designed to give them the skills and techniques necessary to manage various bioterrorism scenarios." G. Caleb Alexander & John D. Lantos, Commentary, *Physicians as Public Servants in the Setting of Bioterrorism*, 15 CAMBRIDGE Q. HEALTHCARE ETHICS 422, 423 (2006). While this argument was made in the context of bioterrorism, it also could be extended to pandemic-response efforts.

222. See, e.g., Charles B. Rangel, Op-Ed., *Bring Back the Draft*, N.Y. TIMES, Dec. 31, 2002, at A19 ("Service in our nation's armed forces is no longer a common experience. A disproportionate number of the poor and members of minority groups make up the enlisted ranks of the military, while the most privileged Americans are underrepresented or absent.").

223. See *id.* Rangel argues that "shared sacrifice" forces those in positions of authority to consider carefully the costs of war:

I believe that if those calling for war knew that their children were likely to be required to serve—and to be placed in harm's way—there would be more caution and a greater willingness to work with the international community in dealing with

considerations are linked to concerns about a potential moral hazard. This danger is attenuated with pandemic response efforts because, once a pandemic has started, there will be no choice but to respond by deploying health care professionals. Unlike a war on foreign soil, where withdrawal or troop reduction is always a possibility, policymakers will not be in a position to back off from pandemic response efforts until the health threat is eliminated, regardless of the socioeconomic background of the individuals who have volunteered to serve.

B. MINIMIZING AND RESPONDING TO RISK

Policymakers should ensure that the risks to individuals who volunteer during a pandemic are reduced as much as reasonably possible.²²⁴ At the most basic level, this includes ensuring an adequate supply of protective equipment, such as masks and respirators. During the SARS crisis, the failure to provide these supplies in some countries “led to a ‘state of panic’ among some health care workers”²²⁵ and may have contributed to these countries’ relatively high rates of worker absenteeism.²²⁶

To further reduce the risk of volunteering, health care professionals should also receive priority access to antiviral medications and, as they become available, vaccines. It is virtually certain that the supply of antivirals and vaccines during a pandemic will be insufficient to meet the demand, so some sort of prioritization method will have to be implemented.²²⁷ Giving priority to health care professionals and other critical service providers should be one of the least controversial allocation decisions, as it can be justified both as an incentive to work and as compensation for risk-taking. In addition, unlike financial incentives, it has the advantage of providing an incentive that is just as attractive to the wealthy as it is to the poor.

Iraq. A renewed draft will help bring a greater appreciation of the consequences of decisions to go to war.

Id.; see also Diane H. Mazur, *Why Progressives Lost the War When They Lost the Draft*, 32 HOFSTRA L. REV. 553, 562 (2003) (“[A] draft that imposes shared obligation for military service ensures a military that is more representative of the society from which it draws its members . . .”).

224. See WORLD HEALTH ORG., ETHICAL CONSIDERATIONS IN DEVELOPING A PUBLIC HEALTH RESPONSE TO PANDEMIC INFLUENZA 14 (2007), http://www.who.int/csr/resources/publications/WHO_CDS_EPR_GIP_2007_2c.pdf (stating that governments and employers have a “[r]eciprocal obligation[]” to “minimize risks to health-care workers to the extent reasonably possible”).

225. ROTHSTEIN ET AL., *supra* note 76, at 135 (quoting Monique Chu, *Health Workers Nervous About SARS in Taiwan*, USATODAY.COM, June 2, 2003, http://www.usatoday.com/news/health/2003-06-02-sars-usat_x.htm).

226. See *supra* note 76 and accompanying text.

227. See DHHS & DHS GUIDANCE, *supra* note 185, at 2 (“It is recognized that [enough] vaccine supply to [vaccinate all persons] will likely not be available all at once . . . [A]llocation decisions will have to be made.”).

Health care professionals who work during a pandemic should also be confident that, if they do become sick, they and their families will not be abandoned. Offering medical and psychosocial support, ensuring the availability of workers' compensation for volunteer workers,²²⁸ and, for workers who die, providing death benefits for family members²²⁹ can help encourage this confidence. Clearly articulated government support for these programs will be critical to counteract the impression of abandonment created by inadequately funded programs to care for workers who responded to the September 11th attacks.²³⁰

C. LIABILITY PROTECTIONS

Some health care professionals who would otherwise be willing to work during a pandemic may be reluctant to do so because of fear of liability. According to a survey of members of the American Public Health Association, almost seventy percent of respondents said that immunity from lawsuits would be "important" or "essential" to their decision about whether to volunteer.²³¹ A recent empirical study suggests that the existence of immunity protections can have a significant impact on individuals' willingness to volunteer.²³²

Health care professionals are probably exaggerating the liability risks they would face for treating patients during a pandemic. It may be that, during a crisis, health care professionals will not always be able to adhere to customary methods of providing medical treatment,²³³ but that does not mean that the risk of liability would be greater than usual. From a liability perspective, the question would not be whether health care professionals

228. See Hodge et al., *supra* note 41, at 50–56 (discussing the application of workers' compensation to volunteer health professionals).

229. See WORLD HEALTH ORG., *supra* note 225, at 15 ("Governments should use their best efforts to develop or strengthen benefits systems that will provide . . . death benefits to the family members of health-care workers who die after being exposed to the pandemic influenza virus in the course of their work." (emphasis omitted)).

230. See Anthony DePalma, *9/11 Workers Not Getting Enough Care, Report Says*, N.Y. TIMES, July 25, 2007, at B3 ("Almost six years after the terrorist attack on New York, the federal government still does not have an adequate array of health programs for ground zero workers . . .").

231. Sharona Hoffman, *Responders' Responsibility: Liability and Immunity in Public Health Emergencies*, 96 GEO. L.J. 1913, 1917 (2008).

232. See Jill R. Horwitz & Joseph Mead, *Letting Good Deeds Go Unpunished: Volunteer Immunity Laws and Tort Deterrence*, J. EMPIRICAL LEGAL STUD. (forthcoming 2008) (manuscript at 3, on file with the Iowa Law Review), available at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1150835 (offering "new, albeit preliminary, evidence suggesting that individuals reduce their activity-level engagement by foregoing volunteering in the face of liability exposure").

233. See HEALTH SYS. RESEARCH, INC., ALTERED STANDARDS OF CARE IN MASS CASUALTY EVENTS 5 (2005), available at <http://www.ahrq.gov/research/altstand/altstand.pdf> ("[I]t is possible that a mass casualty event . . . could compromise, at least in the short term, the ability of local or regional health systems to deliver services consistent with established standards of care.").

provide “standard care” during a pandemic—i.e., the care that would ordinarily be provided in nonpandemic situations—but whether they complied with the legal “standard of care,” which requires care that is reasonable under the circumstances as they actually exist.²³⁴ During a pandemic, “[s]ome mistakes that might ordinarily constitute negligence may not give rise to liability because they were reasonable or unavoidable under the circumstances.”²³⁵ Indeed, courts have recognized that, in assessing the reasonableness of medical treatment, resource limitations are a relevant factor to take into account.²³⁶

Nonetheless, health care professionals’ concerns about liability for working during a pandemic are not entirely unfounded. First, not all health care professionals are used to working under emergency conditions, and even those who are may find the circumstances of working in a pandemic unusually intense. It is not unreasonable to think that some health care professionals will make more mistakes as a result of these pressures. Second, even if some deviations from standard procedures can be justified because of emergency conditions, that does not mean that a patient who suffers an injury (or the patient’s survivors) will not bring a lawsuit. The burden of defending a lawsuit can be considerable, even if the defense is ultimately successful.

Many legal protections already exist for health care professionals who volunteer during a pandemic. For example, most states have “Good Samaritan” statutes that protect physicians from liability for ordinary negligence if they provide emergency treatment in the absence of a legal obligation to do so.²³⁷ In addition, federal and state volunteer-protection statutes give immunity to persons who volunteer for government organizations and nonprofit associations.²³⁸ However, these laws generally do not apply to persons who accept compensation for their services.²³⁹

To close this gap, one commentator has proposed a comprehensive immunity statute for all health care providers who act in good faith in response to a declared public-health emergency.²⁴⁰ The immunity would apply as long as the provider did not engage in “willful misconduct, gross negligence, or criminal activity.”²⁴¹ This approach would remove a

234. See Hodge et al., *supra* note 41, at 33 (“The circumstances of the emergency as a whole play a role in establishing the standard of care for . . . health practitioners . . .”).

235. Hoffman, *supra* note 232, at 1926.

236. See, e.g., Hall v. Hilbun, 466 So. 2d 856, 872–73 (Miss. 1985) (discussing the “Resources-Based Caveat to the National Standard of Care”).

237. See Hoffman, *supra* note 232, at 1943 (explaining “Good Samaritan” statutes).

238. See *id.* at 1944–45 (discussing the Federal Volunteer Protection Act of 1997, and noting that “[a]ll fifty states have adopted their own volunteer protection statutes”).

239. See *id.* at 1944 (citing 42 U.S.C. § 14505(6) (2000)).

240. See generally *id.* at 1959–65 (explaining the proposed statute).

241. *Id.* at 1959.

significant disincentive to volunteering without depriving individuals of compensation for truly “egregious behavior.”²⁴²

In addition to providing civil immunity, states should ensure that health care professionals who volunteer during a pandemic are protected from unwarranted criminal repercussions. For example, some commentators have suggested that, because there is likely to be a severe shortage of ventilators during a pandemic, it would be appropriate to withdraw ventilators from patients with extremely “poor prognoses” so that the equipment will be available for patients more likely to survive.²⁴³ However, withdrawing a ventilator without the consent of the patient or the patient’s legally authorized representative would normally be considered a form of homicide if the patient dies as a result of the withdrawal.²⁴⁴ In a few jurisdictions, ventilators cannot be withdrawn from patients who lack decisionmaking capacity without “clear and convincing evidence” of the patient’s prior decision to terminate treatment under the circumstances presented, a standard that is extremely difficult to satisfy.²⁴⁵ States should first consider whether it would be appropriate, as a policy matter, to allocate ventilators during a pandemic based on patients’ capacity to benefit. If states implement such a policy, they should ensure that health care professionals who follow these allocation policies will be immune from criminal prosecution for homicide.

D. PROFESSIONAL NORMS

This Article has argued that, in the absence of a general expectation that individuals will assume risks for the benefit of others, society should not expect individuals to work during a pandemic based solely on their status as licensed health care professionals. While it is legitimate to sanction individuals for failing to live up to their prior commitments, society has no right to expect health care professionals who have not previously assumed any patient-care obligations to act more altruistically than the rest of the population.

242. See Hoffman, *supra* note 232, at 1967 (“While egregious behavior will be deterred by the prospect of liability, the threat of liability will not loom so large that it deters individuals . . . from participating in emergency response activities or punishes them for their willingness to provide aid, as it will not attach to simple negligence.”).

243. See N.Y. STATE TASK FORCE ON LIFE & THE LAW, *supra* note 33, at 35 (“Patients who fail to meet rationing criteria have poor prognoses and will be taken off ventilators.”).

244. See Hoffman, *supra* note 232, at 1934 (“When an emergency strikes and the demand for respirators exceeds supply . . . physicians might be tempted to remove respirators from . . . elderly patients in order to give them to . . . younger patients Such acts, however, could be considered killings under criminal law.”).

245. See Norman L. Cantor, *Discarding Substituted Judgment and Best Interests: Toward a Constructive Preference Standard for Dying, Previously Competent Patients Without Advance Instructions*, 48 RUTGERS L. REV. 1193, 1205–06 (1996).

However, there is a difference between expectations that are imposed on health care professionals from the outside, such as those reflected in legislation, and self-imposed expectations that professionals adopt to guide their own behavior. Thus, nothing in this Article is intended to undermine professional associations' efforts to instill an ethic in favor of volunteering during pandemics and other disasters. Similarly, this Article is not inconsistent with efforts by professionals associated with particular institutions, such as the members of a hospital's medical staff, to create a climate in which volunteering during emergencies is seen as an expected type of collegial behavior.²⁴⁶

Even though these self-imposed expectations would not be legally binding, they are likely to have a considerable influence on health care professionals' attitudes and behaviors. As legal scholars have increasingly recognized, individuals are powerfully influenced by social norms—i.e., beliefs about what “ought to be done and what ought not to be done.”²⁴⁷ Individuals tend to comply with social norms even if the legal penalties for noncompliance are minimal or nonexistent, both to avoid the negative consequences of noncompliance (such as guilt or social ostracism)²⁴⁸ and to reap the positive advantages of being perceived by others as “good.”²⁴⁹ Ultimately, peer pressure may be a greater motivator for health care professionals than any formal system of externally imposed sanctions.

CONCLUSION

The potential shortage of health care professionals during a pandemic is a frightening possibility. It is understandable that some lawmakers have responded to this fear by instituting new legal requirements. Yet fear is a dangerous basis on which to ground public policy.²⁵⁰ This Article has argued

246. Cf. Iserson et al., *supra* note 75, at 349 (suggesting that “[h]ealth care personnel may . . . fear the shame of abandoning their colleagues in a time of crisis” and that this fear may “act as a motivator”).

247. Cass R. Sunstein, *Social Norms and Social Roles*, 96 COLUM. L. REV. 903, 914 (1996).

248. See *id.* at 915 (“If someone behaves in a way inconsistent with social norms, public disapproval may produce embarrassment or perhaps shame and a desire to hide. Sometimes the unpleasant feelings brought about by violations of social norms are intense, and the social consequences of these feelings . . . can be substantial.”).

249. See Sarah E. Waldeck, *Using Male Circumcision to Understand Social Norms as Multipliers*, 72 U. CIN. L. REV. 455, 461 (2003) (“[S]ignaling theory posits that norms develop as individuals try to signal that they are of a ‘good type’—i.e., that they are the sort of people with whom others should cooperate.”).

250. As the American Civil Liberties Union has observed: “The notion that we must ‘trade liberty for security’ is both false and dangerous. It is false because coercive actions are seldom conducive to public health protection. It is dangerous because it provides a never-ending justification for the suppression of civil liberties while failing to safeguard public health.” GEORGE J. ANNAS ET AL., AM. CIVIL LIBERTIES UNION, PANDEMIC PREPAREDNESS: THE NEED FOR A PUBLIC HEALTH—NOT A LAW ENFORCEMENT/NATIONAL SECURITY—APPROACH 8 (2008), http://www.aclu.org/pdfs/privacy/pemic_report.pdf.

that compelling health care professionals to work during a pandemic regardless of their pre-existing treatment obligations would impose burdens that cannot be justified by health care professionals' ethical commitments. Rather than singling out health care professionals for such special obligations, policymakers should adopt measures that encourage all individuals who could be useful during a pandemic to work voluntarily.