Medical ethics experts identify, address key issues in H1N1 pandemic

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The anticipated onset of a second wave of the H1N1 influenza pandemic could present a host of thorny medical ethics issues best considered well in advance, according to the University of Toronto Joint Centre for Bioethics, which today released nine papers for public discussion.

Topics include duty of health care workers to work during a serious flu pandemic; government restrictions on individual freedoms and privacy and their responsibilities administering vaccination programs; how to allocate limited medical resources; and the obligation of rich countries to share such resources with those less fortunate.

"While we hope there will not be a major second wave of the H1N1 flu, there is limited cause for optimism and we could well see the pandemic's full onset late this year or early next when the traditional flu season begins," says JCB Director Ross Upshur.

"Now is the time to think through the serious ethical challenges societies may confront, not in the midst of crisis with line-ups at hospital doors. These issues and concerns, though drawn largely from a Canadian point of view, have relevance to countries everywhere."

JCB's Canadian Program of Research on Ethics in a Pandemic (CanPREP) prepared the papers with the benefit of both academic and public opinion research, obtaining the views of 500 Canadians through a national telephone survey and nearly 100 more via a series of town hall meetings nationwide.

Dr. Upshur, who is also Director of the Pan American Health Organization / World Health Organization Collaborating Centre for Bioethics, will host a symposium on the issues Weds. September 23, 88 College Street, Toronto, attended by health care providers, professional college representatives, community organizations and the public.

Duty to care

Competing obligations may explain why 25 to 85% of health care workers (HCWs) report being unwilling to work in a pandemic, according to the papers.

Do HCWs have an obligation to treat patients despite risk of infection? What limits, if any, are there to health care workers' duty to care? What institutional supports are owed to health care workers in a pandemic?

Important documents such as codes of ethics and professional directives are unclear on the question of acceptable risk for HCWs.

The JCB says 90% of those surveyed believe HCWs should report to work and face all risks provided safety precautions are provided. 85% believe governments should provide HCWs with free disability insurance and death benefits during a flu crisis and 84% think HCWs who feel unsafe at work have a right to file a grievance.

The public, though, was somewhat conflicted on what to do with HCWs who do not come to work without a legitimate reason. Almost half (48%) agree they should face loss of employment or professional license, 38% disagree. The sharpest division appears with respect to the government using conscription of HCWs during a pandemic: 47% agree, 43% disagree.

The research showed strong agreement that health care professionals

have an implicit social contract based on their profession and training to provide care under adverse conditions.

The researchers heard from study participants that, "like soldiers, HCWs should be expected to uphold their duties no matter how challenging and frightening the situation. On the other hand, the group also felt that the government and health care organizations had reciprocal obligations to protect health care professionals from elevated risks in all ways possible, including policies to ensure a safe working environment."

The obligation to work is not without qualification, as 89% of survey participants agreed that a serious health problem that could increase flu vulnerability was a legitimate excuse from work.

The public was less supportive of competing care obligations such as young children or elderly relatives: 57% agreed that caring for a family member is a legitimate reason to not work.

A related paper dedicated to their legal obligations says health care providers (HCPs) who breach the "duty to care," causing a patient to suffer an injury or loss, may be guilty of negligence and forced to pay damages.

"There has been limited case law, literature, and legislation on what a HCP's legal duty to care is during a pandemic," the authors say. "HCPs can gain insight into their obligations by informing themselves about the general legal doctrines developed in non-pandemic cases and legislation."

Priority setting

The JCB papers say a major pandemic will demand difficult ethical choices related to ventilators, vaccines, antivirals and other resources.

Who should get the last bed and ventilator in an intensive care unit, for example: an accident victim suffering a severe but potentially reversible brain injury or a nurse who contracted the flu while caring for patients in the hospital?

Should resources be allocated to save the most lives or to give everyone a fair chance at survival? Should special consideration be given to vulnerable populations in determining access to resources? Who should make these allocation decisions?

The authors say some of the ethical goals of priority-setting involve legitimacy, fairness and equity. Public participants in JCB research, meanwhile, identified three considerations in priority-setting decisions: need, survivability, and social value.

Need was described as giving resources to those most sick or those directly responsible for the care of others (such as elderly parents). Participants also suggested that scarce resources be given to individuals most likely to benefit and survive, and that consideration be given to the social value of health care workers, police officers or others integral to a functioning society in a pandemic crisis.

Those surveyed seem conflicted when it comes to allocating medicines. While 59% believe every Canadian should have an equal chance of receiving antivirals, 94% say health care providers should receive priority in a pandemic, while 89% believe children should be given second priority.

Participants suggested predetermined guidelines or criteria could help decision-makers formulate concrete allocation decisions in the context of an actual pandemic influenza.

As well, there should be an appeals process open to persons denied

resources and all decisions taken should be transparent in order to engender a sense of public trust.

Should time not permit preliminary deliberation on allocation criteria, participants felt one appointee should make decisions since efficiency would become vital.

Finally, public participants expressed skepticism about the capacity of Canada's health care system to respond effectively to an influenza pandemic. They noted that priority setting is already a challenge in Canadian health care and that an outbreak of H1N1 would simply highlight and exacerbate that weakness.

Despite this, approximately 91% of survey participants identified saving lives as the most important goal of pandemic influenza preparations, with 41% endorsing saving lives solely in Canada as the highest priority and 50% endorsing saving lives globally as the highest priority.

H1N1 vaccinations

Coercion in vaccination policy could range from aggressive marketing campaigns, to introducing policies that exclude unvaccinated individuals, to introducing mandatory vaccination.

In order for public health officials to justify the more coercive measures, they need scientific evidence that supports the population health benefits of the vaccination program.

"Arguably, the greater the evidence for population health benefit, the more coercion is permitted," according to the papers.

"To determine the ethical principles that govern an H1N1 vaccination program, it is first essential to determine the purpose of the program.

Are public health officials primarily making the vaccine available to Canadians for their own protection? In this instance autonomy of decision-making and individual liberty would predominate as guiding principles. Under these circumstances there can be little justification of any coercion on the part of public health officials, in particular the use of mandatory vaccination legislation, and the government's reciprocal responsibilities to vaccine recipients are limited.

"Or is the objective of the program to reduce the population health effects of the virus? In this case principles of solidarity and the protection of the public from harm could predominate over individual liberty. Public health officials can be justified in introducing more coercive policies. However, accompanying this infringement of individual liberty is an increase in the government's reciprocal responsibilities to vaccine recipients."

Rarely, some individuals may be harmed by a mass vaccination program and "the more coercive the strategy, the greater are the reciprocal responsibilities of the state to the vaccine recipients.

"Two key elements of reciprocity would include the creation of enhanced (vaccine) safety and effectiveness post market surveillance and the introduction of a no-fault compensation program for post-vaccination adverse events."

Restrictive measures

Governments may need to limit three basic personal freedoms - mobility, freedom of assembly, and privacy - in order to protect the public good.

JCB authors ask readers to imagine an order by public health officials to close community centers and cancel all large public gatherings.

One family, whose two daughters were killed in a car accident, plans to hold a large memorial service with family and friends the following day with over 500 attendees expected. Should public health officials prevent it from happening?

In the aftermath of SARS, JCB research showed that citizens understood and accepted the need for restrictive measures to control the spread of infection.

Most saw it as a form of civic duty and were willing to accept limits to their individual liberties for the public good.

A large majority (85%) of survey respondents agreed that governments should have the power to suspend some individual rights (e.g. traveling, right to assemble) during a pandemic influenza.

However, they also contended (95%) that there is a reciprocal obligation of governments to provide food, shelter, social support and other basic needs of restricted individuals and support services after restrictive measures end (79%).

And they argued that restricted individuals should not be penalized by an employer for following a quarantine order (e.g., losing a job).

Half of survey respondents reported that violation of an appropriate quarantine order was equivalent to manslaughter.

Managing a pandemic flu outbreak, including the use of restrictive measures, requires a citizenry that is informed, engaged, and responsive, according to the JCB papers. "This means involving citizens prior to the outbreak as policy and plans are set as well as during the outbreak when these will be implemented."

Among other recommendations, the authors urge public health officials to ensure that pandemic flu plans include a comprehensive and transparent protocol for implementing restrictive measures, founded on the principles of proportionality and least restrictive means, balancing individual liberties with protection of public from harm, and with safeguards such as the right to appeal built in.

Global ethics

What obligations, if any, do Canadians have to support poorer countries in response to a flu pandemic? Should countries have the right to close their borders to travelers coming from affected areas? How might a collaborative focus on minimizing harms, avoiding stigmatization, and preventing unnecessary constraints on international travel and trade be fostered and maintained?

According to the JCB authors, "in the face of an H1N1 pandemic influenza and other threats to global public health, anything less than the mobilization of substantial enduring financial and other support will amount to an abdication of the shared responsibility for global health and of the fundamental values of equality, reciprocity, and justice."

Canadians not only recognize the lack of equality, reciprocity and justice at the global level, but regard them as ethical imperatives and support policies that take aim at changing current realities. For example, a majority of survey respondents (54%) gave priority to saving lives globally over saving lives of Canadians (36%) in response to an influenza pandemic.

A strong majority (70%) of those surveyed agreed that Canada should provide international assistance to poorer countries facing a pandemic, even if this means fewer resources for Canadians as a result. When asked how much assistance should be provided, most Canadians (92%)

responded that aid should amount to at least 7% of total resources committed to pandemic preparedness, and many (43%) felt that that amount should be 10% or more.

Participants thought that Canada ought to assume a more prominent leadership role internationally and that the traditional distinction between public and private sector responsibilities needed to change in order to mount an effective global response to the pandemic.

Support ran high for increasing regulatory control over drug manufacturing capacity and profit-seeking, and for prioritizing equity in global distribution of drugs. Town Hall participants were less united on the extent to which domestic obligations and the recent global economic downturn should modulate Canada's duty to reach out globally.

Among the authors' recommendations: Canada should share at least a 10% portion of its national stockpile of antiviral medications, H1N1 vaccine allocations, and outbreak management kits with poor countries, and encourage other wealthy countries to follow suit.

It should also seek global reassurances that vaccine priority will be given to health care workers, as well as the most vulnerable (children under five, pregnant women, people with weak immune systems and members of indigenous communities.

"Prioritizing the most vulnerable in other countries prior to the least vulnerable in this country would contribute immensely to allaying fears that the rich will live and the poor will die during a worsening global influenza pandemic."

As well, Canada's domestic vaccine producers should maintain full production capacity for as long as there is need in other countries and even after all Canadians have been offered vaccines. Consideration of

the use of adjuvants in order to extend the overall vaccine supply should also be a priority, as should exploration of policy initiatives to create a global network of regionalized vaccine production sites insulated from market forces.

Risk communication

During the 2003 SARS crisis, poor communication between public health officials, health care workers and the public was cited as a major factor contributing to the confusion and even spread of the virus.

According to the JCB papers: "For people to accept public health measures that may limit their individual liberty and potentially cause them to be stigmatized, they must trust the information they receive as well as the authorities who provide the information."

Information must be available through a variety of sources for both professionals and the public, and recipients should know where information is coming from and from whom. Being transparent also means being open about what is known and what is not known about the situation, the authors add.

For citizens to be honest about their own health, the state need to acknowledge that transparency will not be penalized. For example, someone who accepts voluntarily quarantine needs assurance they will not lose their job.

Likewise, at the international level, "countries need to be able to trust each other to be transparent and honest about infectious disease outbreaks.

"Reciprocally, countries that do not trust the international community to be fair and to provide assistance may fear things such as economic loss

as a consequence of having open and honest communications about outbreaks. The result may be that they chose not to be transparent with the global community."

"If countries have a moral duty to be transparent, then the global community has reciprocal moral obligations to compensate and support those countries that may suffer economic or health consequences as a result of transparent communication."

Vulnerability

Although the prevalence of chronic and acute diseases is higher among elderly and other certain groups, stakeholders felt that it was important to distinguish between age and disease and noted that age should not be a proxy for disease or provide the basis for allocation decisions.

In places, isolation due to geography may increase vulnerability.

"In Northeastern Ontario alone, the land mass is equivalent of Spain and Portugal combined, so 100,000 square miles, so logistical distribution of emergency supply and stockpile is a huge issue".

A particular challenge noted by many stakeholders: pandemic influenza planning occurs primarily at urban centres, for urban centres, thus not being sensitive to the difficulties that might arise in rural areas. Similarly disadvantaged: those who live in poverty or in crowded housing conditions such as shelters and prisons.

Source: University of Toronto (news : web)