Planning and response to the influenza A (H1N1) pandemic: ethics, equity and justice

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Abstract

This paper aims to highlight three ethical considerations related to influenza pandemic planning and response: ethical allocation of scarce resources; obligations and duties of healthcare workers to treat patients, and the balance between conflicting individual and community interests. Among these, perhaps the most challenging question facing bioethics is how to allocate scarce, life-saving resources given the devastating social and economic ramifications of a pandemic. In such situations, the identification of clear overall goals for pandemic planning is essential in making difficult choices. The dilemma between the duty to save patients and the right to protect the healthcare personnel's own life and health is a key issue. During the course of a pandemic, civil liberties may also be threatened, requiring limits on individual freedom to protect individuals as well as entire communities. Yet, individual liberty should be restricted with great care, and only when alternative approaches are not effective. Pandemic influenza planning and response should be a cooperative and shared responsibility that balances community and individual interests.

Introduction

Periodically, novel influenza viruses emerge and spread rapidly through susceptible populations, resulting in worldwide epidemics or pandemics. Three major pandemics occurred in the 20th century. The first and most devastating of these, the "Spanish Flu" (A/H1N1) pandemic of 1918-19, was estimated to have resulted in 20-50 million or more deaths worldwide. Mortality associated with the 1957 "Asian Flu" (A/H2N2) and the 1968 "Hong Kong Flu" (A/H3N2) pandemics was less severe, with the highest excess mortality in the elderly and persons with chronic diseases (1). On April 15, 2009, a novel swine-origin influenza A (H1N1) virus was identified from specimens of two epidemiologically unrelated patients (2). Over the next two months, the virus spread to 170 countries. On June 11, 2009, the World Health Organisation (WHO) declared a pandemic phase 6 for influenza (A/H1N1) and we moved into the first influenza pandemic of the 21st century (3).

In addition to high levels of morbidity and mortality, an influenza pandemic could be accompanied by significant social disruption and economic impact. The number of people requiring medical intervention could overwhelm healthcare facilities, the supply of antiviral drugs may not be sufficient to address the demand, and delays and shortages in the availability of vaccines are expected. Potential public health interventions that target reducing the spread of the infection (e.g. interventions such as isolation of ill individuals and quarantine for exposed people) would result in disruption of the usual activities and essential services (4).

Many critical ethical issues arise in pandemic influenza planning, preparedness and response. These include the following questions: Who will get priority access to medications, vaccines and intensive care unit beds, given the potential shortage of these essential resources? In the face of a pandemic, what obligations do healthcare workers have to work notwithstanding risks to their own health and the health of their families? Finally, how can surveillance, isolation, quarantine and social-distancing measures be undertaken in a way that respects ethical norms? (5) Increased attention has been focused on the need for pandemic influenza plans to address these ethical questions (6-10). In addition, several international and state health organisations have developed ethical guidance for responses to pandemic influenza (4-5, 11-15).

Experience with previous health emergencies has shown that, without a clear ethical framework and an understanding of the decision-making process, decisions may not be readily accepted either by healthcare workers or by other members of an affected community and may result in long-term psychological repercussions such as anxiety, post-traumatic stress disorder, and depression (16). This has been witnessed during the Severe Acute Respiratory Syndrome (SARS) epidemic in Toronto (17), wherein the costs of not addressing ethical concerns were severe: hospital staff morale was low, there was confusion about roles and responsibilities, misinformation was spread, and vulnerable communities were stigmatised.

The present paper, prepared after a critical review of the literature available on the subject, aims to highlight the importance of an ethical process in planning for a pandemic and show how various ethical dilemmas can be addressed during the preparedness and response phases.

Resource allocation

Oshitani et al (18) reported that with an incidence rate of 35%, four out of five of all hospital beds would be required for patients with pandemic influenza in low-income countries. In countries like Bangladesh and Nepal, every single bed would be required for patients with pandemic influenza, even at the incidence rate of 15%. But a study of 45 national pandemic plans including both developing and developed nations revealed that not one plan included a prioritisation scheme for distribution of non-pharmaceutical medical resources such as

ventilators and N95 masks (19). A scrutiny of pandemic plans for influenza A (H1N1) of the government of India highlighted the lack of attention to ethical issues in resource allocation, in addition to inadequate intensive care competencies, equipments and diagnostic laboratories (20).This further accentuates the need to address the ethical issues involved in allocation of limited resources.

Many different ethical principles can be applied to priority-setting in healthcare. The principle of utility suggests that resources should be used to provide the maximum possible health benefits, often understood as "saving most lives". The principle of equity requires that the distribution of benefits and burdens be fair. When these principles are in conflict, the appropriate balance to be struck should be determined in a transparent process that takes into account local circumstances and cultural values (5).

Historically the organising principle for resource distribution in inter-pandemic years has been the minimisation of serious influenza-associated complications. Individuals most at risk of hospitalisation or death if infected are given priority in receiving influenza vaccinations. However, it is suggested that in pandemic influenza management, a second principle - that of preserving the functioning of society - should receive greater priority in decision making than preventing serious complications. Those individuals who are essential to the provision of healthcare, public safety and the functioning of key aspects of society should receive priority in the distribution of vaccines, antiviral drugs, and other scarce resources. Engagement of diverse stakeholders will be essential in affirming this priority, determining who is considered key to the functioning of society, and establishing a distribution strategy that allows for decisions to be made when resources are limited. In any prioritisation proposal, it must be made clear that maintaining the functioning of society may take resources away from those at high risk for severe medical complications due to pre-existing medical conditions or advanced age. A classic utilitarian approach to defining priorities, "the greatest good for the greatest number," is not a morally adequate platform for pandemic influenza planning (4).

Such policies should be developed with great care, as those which favour certain categories of workers may be perceived as unfair and undermine public trust. During different phases of a pandemic, such techniques will need to change or adapt. A robust decision making process used for resource rationing will be important. The process should be developed in advance in a systematic, reproducible, transparent, flexible and fair way, and should involve public participation. The distribution plans should mention: what scarce goods are covered, who is eligible to be a recipient, and what morally relevant criteria will be used to assign higher or lower priorities to groups or individuals within the determined goal (4).

Duty to treat

Dr Joanna Tse Yuenman, a 35 year old respiratory physician, was the first public hospital doctor to die from SARS during the 2003 Hong Kong epidemic (21) and her death generated a great outpouring of public emotion in Hong Kong. The two quotes that highlight the sentiments regarding her sacrifice are - "as a doctor her duty was to save lives" and ''...the dedication and professionalism of the front line medical personnel went far beyond the simple duties of a job" (22).

A successful response to an influenza pandemic depends greatly on the attitudes, skills and efforts of healthcare workers (HCWs) but an uneasy balance exists between the duty to save lives and the extent to which they may be asked to risk lives to satisfy this duty (8). Do medical professionals have moral obligations to patients and society that must be met, even at risk to their own lives? There are three strong arguments that can be made to support the view that such an obligation does exist: the oaths taken by HCWs, the privileges they enjoy, and the special skills they possess (22). Though the extent to which HCWs are obliged to risk their lives to deliver clinical care is difficult to quantify, they are unique in their ability to provide care, and it can be argued that this increases their professional obligation to provide it (23).

On the other hand, HCWs have an ethical duty not to harm, and not to contaminate other healthcare personnel, patients and their own family and friends. The duty of physicians is to protect public health while doing their best for individual patients (24). Clinicians are multiple agents, belonging to the medical profession but also to other moral communities. A physician may also be a husband, a parent, a brother, and a son, and each of these roles carries its own obligations. When the risks to oneself are high and transmission of infection to loved ones a distinct possibility, the prima facie obligation to care for the sick may conflict with other non-clinical moral obligations (25).

The willingness to work on cases of a severe and potentially lethal infectious disease has been investigated in several studies. In a random sample study among US physicians, 40% announced that they were willing to put themselves at risk of contracting a deadly illness to save others' lives (26). In a survey of HCWs conducted across three National Health Service trusts in the West Midlands, UK, 76.8% respondents agreed that doctors and nurses had a duty to the sick despite risks (27). In a Taiwanese survey, 57% of nurses indicated that they were willing to care for patients infected with avian influenza but nearly 42% of them did not think that, if there were an outbreak of avian flu, their working hospitals would have sufficient infection control measures and equipment to prevent nosocomial infection in their working environment (28). These risk reduction methods are important for the protection both of healthcare workers and of the public.

If society affirms that HCWs should work despite high personal risk, society in turn has a responsibility to support and protect them. Workers on the other hand have an ethical obligation not only to use the protective measures that are offered to them, but also to report if they become infected and to accept temporary exclusion from work until they are no longer infectious (5). Healthcare organisations must ensure the safety

and protection of its workers and support them at the time of a pandemic. Decision makers should work collaboratively with stakeholders and professional institutions in advance of an influenza pandemic to establish practice guidelines, develop fair and accountable processes to resolve disputes, provide support to ease this moral burden of those with the duty to care, and develop means through which institutions will handle appeals or complaints, especially with regards to work exemptions or the vaccination/prophylaxis of staff (15). Healthcare workers should be kept informed about the situation and what is expected from them. They should be encouraged to formulate their responses, which should then be discussed in open forum. Healthcare administrators must implement procedures that maximise the safety of frontline physicians and nurses before they ask them to treat patients during a pandemic (20).

Isolation, quarantine and social distancing

Management of an influenza pandemic also involves interventions that limit the freedom of movement of individuals or create conditions of social distancing. Isolation of infected persons, quarantine of exposed persons, and quarantine of a geographic area (*cordon sanitaire*) are complex and ethically controversial public health powers that call for balancing the interests of the community and the rights of the individual (9).

Kinlaw et al (4) and Kass (29) have proposed ethical frameworks for the implementation of social distancing and other practices restricting personal freedom when managing pandemic influenza. Kass (29) suggests a six-step framework to guide public health officials in choosing an ethically sound course of action by evaluating the various options available to them. According to Kinlaw et al (4), the proposed use of such interventions and procedures should be in the form of recommendations for voluntary action. Requirements for mandatory liberty-limiting and social distancing interventions should be imposed only in cases in which voluntary actions seem unlikely to be effective. Legitimate restrictions on individual freedom may occur if, in exercising one's freedom, one places others at risk. An individual does not have the right to injure another or to take someone's property merely because she or he wishes to exercise her or his freedom. In addition, implicit in membership in society is an obligation to abide by certain ethical and legal constraints to enjoy the benefits of membership in that society. The guiding principles in determining these restrictions include: adoption of least restrictive practices that will allow the common good to be protected; ensuring that restrictions are necessary and proportional to the need for protection; and ensuring that those affected by restrictions receive support from the community.

Isolation and quarantine are extreme measures that require rigorous safeguards, including scientific assessment of risk and effectiveness, a safe and habitable environment, procedural due process, and the least restrictive alternative (9). The process for decision making about restrictions should be well thought out in advance. Both the decision makers and the criteria that will be used to determine when restrictions will be implemented should be specified. A reasonably diverse infrastructure that includes voices across racial, cultural, community, provider, and recipient groups should be involved in planning, understanding the process, and conveying the process throughout the community. In pandemic influenza, centralisation of decision making may be important in creating fair and equitable restrictions that will apply across communities. Legal authority for isolation and quarantine must be clear and constitutionally acceptable, with criteria based on risk and fair procedures (9). A process should be in place for objections to be heard, for restrictions to be appealed against, and for new procedures to be considered before implementation. As in other areas of pandemic influenza management, transparency about the process is essential and communication about restrictions should begin early in the planning process. The public should be clearly informed that restrictions on personal freedom are anticipated, that these limitations may be important to the individual's own protection, and that they are also necessary to limit the spread of disease throughout the community. Experts have stated that the government of India and the health authorities did not have any direct channel of communication with medical personnel during 2009 influenza pandemic, that there was a conspicuous silence from professional medical organisations such as the Medical Council of India and the Indian Medical Association, and that there was "no flow of reliable information" from the health authorities (20).

Conclusion

Influenza pandemics now pose an ever-growing threat and in the near future they may be a cause for much more morbidity and mortality in all age groups. The healthcare system has to gear up further to meet this challenge and plan strategic measures well in advance to face the adversity. Influenza pandemic calls for making certain decisions that require balancing potentially conflicting individual interests with community interests. An ethical approach applies principles such as equity, utility /efficiency, liberty, reciprocity, and solidarity in light of local context and cultural values to assess and balance these competing interests and values. Any measures that limit individual rights and civil liberties must be necessary, reasonable, proportional, equitable, and non-discriminatory (30). The importance of ethics to pandemic planning is in the "the application of value judgements to science" which reflects values because scientific information alone cannot drive decision making. Stakeholder engagement is essential for the ethical framework to be relevant and legitimate. Ethics should be made understandable and subject to open discussion (15).

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Free medical care and consumer protection

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Abstract

This paper will examine the question of whether patients, who receive free medical care, whether from private charitable or governmental hospitals, can claim rights as 'consumers' under the Consumer Protection Act, 1986. The issue will be discussed from a constitutional perspective as well as that of the law of torts.

The courts have recognised the people's right to proper healthcare and have also spelled out standards for such care and standards for determining negligence. In the landmark case of P*aramanand Katara v. Union of India* (1), the Supreme Court of India emphasised the need for rendering immediate medical aid to injured persons to preserve life, and the obligations of the state in this context. In addition to the constitutional mandate, from the viewpoint of tortious liability, the Bolam test lays down that any reasonable man entering an area of work which requires the attainment of a particular level of learning in order to be called a professional of that field impliedly assures those dealing with such a professional that the skill which s/he professes to possess shall be exercised and with a reasonable degree of care and caution (2). In this regard, the Court observed:

> From these general statements it follows that a professional man should command the corpus of knowledge which forms part of the professional equipment of the ordinary member of his profession. He should not lag