

Nova Scotia Health System Pandemic Influenza Plan

Reference 1: Ethical Considerations and Decision- Making Framework

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“Perhaps the sentiments contained in the following pages, are not yet sufficiently fashionable to procure them general favor; a long habit of not thinking a thing wrong, gives it a superficial appearance of being right, and raises at first a formidable outcry in defense of custom. But the tumult soon subsides. Time makes more converts than reason.”

Thomas Paine
Philadelphia, February 14th, 1776

Nova Scotia Department of Health Mission

“Through leadership and collaboration to ensure an appropriate, effective and sustainable health system that promotes, maintains and improves the health of Nova Scotians.”

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Background and Purpose

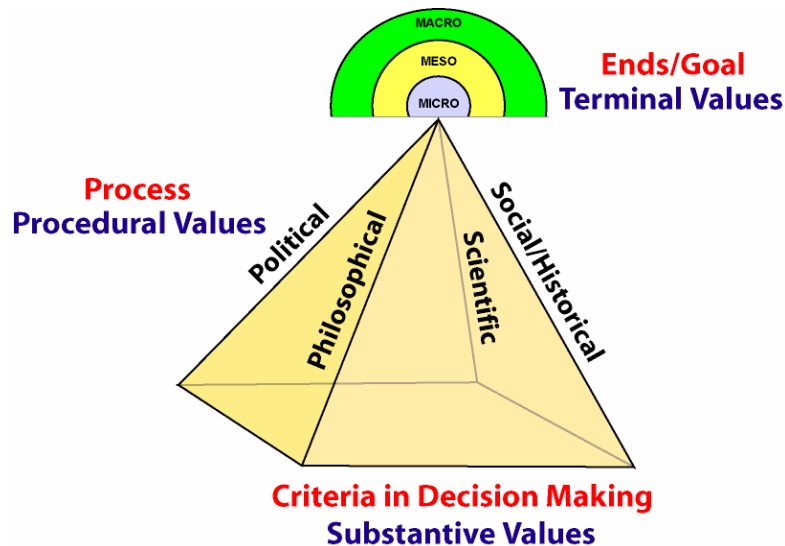
Should a pandemic influenza occur, decisions will have to be made by individuals in virtually every sector, and at all levels of the health-care system, that will fundamentally alter health-care delivery and access to health-care services. The public health ethics literature, including literature on emergency situations, would be an essential source of materials to guide pandemic influenza planning and provide the framework for public health decision making. Unfortunately, very little has been published in this area of critical importance. The “custom” of bioethics has been the “Principles of Bioethics,” which involves respect for autonomy, beneficence, non-maleficence, and justice (Beauchamp and Childress 2001). These principles have been conceived and argued in the context of an “I-self”-centred model (focusing on the individual during health-care encounters). Thus, *prima facie* obligation is given to the principle of respect for autonomy, generating conflicts in applying these principles to community-centred public health contexts (“we-self”).

The following document was designed to move beyond “principlism” and promote thought and reflection on the values inherent in decisions that will have to be made before and during a pandemic. A framework for ethical decision making is provided, including lists of substantive and procedural values, a discussion of emergency versus non-emergency situations, a goal and priority setting guide, and a discussion of challenges to be faced. The latter includes an application of the framework. Accompanying materials and further explanations can be found in the appendices. This document is to accompany the Canadian Pandemic Influenza Plan. It also complements the Nova Scotia Department of Health mission statement and the Nova Scotia Health Services Pandemic Plan.

Introduction

The three primary components of this framework (depicted below as a pyramid) are **substantive values**, the criteria in decision making; **procedural values**, values that guide the process that seeks to achieve an end; and **terminal values**, which shape the ultimate end or goal. There are four additional dimensions that have an influence in decision making: scientific, the evidence; socio-historical, recognition of and respect for cultural and historical perspectives that influence behaviours and beliefs; philosophical, all human endeavours are moral endeavours; and political, the realities of what is feasible, economical, acceptable, and realistic in the political context. The purpose of these

dimensions is to orient the decision maker and to demonstrate that each of these dimensions needs to have a role in policy discourse.



Ethical Considerations from the Canadian Pandemic Influenza Plan

The Canadian Pandemic Influenza Plan includes an Ethics and Pandemic Planning section that describes a set of core values and principles to assist in pandemic planning activities. (Public Health Agency of Canada [PHAC] 2006) This core list, which contains both procedural and substantive values, indicates that we must

- protect and promote the public's health
- ensure equity and distributive justice
- respect the inherent dignity of all persons
- use the least restrictive means
- optimize the risk/benefit ratio
- work with transparency and accountability

These values have been taken into consideration and included in some form in the Nova Scotia Health System Pandemic Influenza Plan's *Ethical Considerations and Decision-Making Framework*.

Substantive Values (Criteria in Decision Making)

The vast and varied scope of public health research and practice necessitates the consideration of a wide range of values and principles. These values have been grouped according to their breadth and scope: policy values (subdivided into policy issues and policy outcomes); social values (justice/fairness, including the subcategory of institutional/organizational values); and individual values.

Suitability and applicability of substantive values will depend on numerous factors, including, but not limited to, the dilemma faced, the operational, and the desired policy outcome (e.g., values may carry more or less weight or may or may not even be applicable in some contexts).

Policy Values		Social Values	Individual Values	
Issues	Outcomes	Justice (Fairness)	Institutional/ Organizational	Individual Values
Necessity	Efficiency	Universality	Interdependence	Liberty
Need	Quality	Equity/equality	Trust/fidelity	Freedom
Urgency	Feasibility	Social responsibility	Loyalty	Dignity
Accountability	Acceptability	Protection of the vulnerable and/or marginalized	Stewardship	Respect for autonomy
Relevance	Effectiveness/ efficacy	Equity of access and outcomes	Solidarity	Privacy/ confidentiality
	Proportionality	Protection from undue stigmatization	Evidence	Harm principle (non-maleficence)
	Sustainability	Protection of human life	Subsidiarity	
	Value for money	Precautionary principle	Duty to provide care	
	Least restrictive means			

Note: Definitions and explanations are included in Appendix A.

Stand on Guard for Thee, a document produced by the University of Toronto Joint Centre for Bioethics Pandemic Influenza Working Group (2005), identifies 10 key substantive values for pandemic planning: individual liberty, protection of the public from harm, proportionality, privacy, duty to provide care, reciprocity, equity, trust, solidarity, and stewardship.

In addition to the core values of public health and protection of the public from harm, the three interrelated values of **equity**, **trust**, and **solidarity** all appropriately focus on the common good and will be particularly salient during public health emergencies such as a pandemic influenza. (Melnychuk and Kenny 2006)

Equity: We must prevent increasing inequities while maintaining and promoting equity. Strategies or measures adopted during a pandemic or other public health emergency should strive to promote equity, while preventing rising inequities.

Trust: We must build and maintain trust in the face of fear and uncertainty. The value of trust extends to both fair processes and treatments. Public engagement and open (transparent) policies, procedures, and deliberations will help build public trust.

Solidarity: A pandemic will affect virtually every aspect of society. We will all have to cope with shortages of goods and services, both within and beyond the health-care sector. Protection of the public and promotion of the common good will necessitate society-wide collaborations.

Procedural Values (Process/Procedure)

The more **fair**, **informed**, **open (transparent)**, and **accountable** the decision-making process is, the more likely it is to result in a good, if not perfect, decision (adaptation of Norman Daniels's accountability for reasonableness). Also relevant in a public health context is responsiveness.

Fair: Whose interests are being served by the decision? Who is at the decision-making table? Are appropriate interest groups, activists, and stakeholders included in the process? Are those most affected by the policy or decision involved in the process? If not, can their exclusion be justified? What is the appropriate balance of elites, experts, and the public for this policy/decision? How are citizens and the community represented? Is there a role for the public and is this role clearly defined: e.g., is their role that of decision making? dialogue? window dressing? Is there competent representation for those who cannot speak for themselves?

Informed: What kind of information is essential for a "good" decision or policy? What information is required to address the policy/decision? Who can you consult so that you are informed? How are the public and elected officials informed? What information is necessary to be informed? How will the public access the forum for public input? How will

the forum facilitate input from those who may not be comfortable with policy debate and discussion?

Open (Transparent): How is the process open (transparent)—or not? Who will create a record of events and decisions or a resource of information that can be consulted by the public or other interested parties?

Accountable: How is the process accountable to the public—those involved in the process and those most affected by the decision?

Responsive: What opportunities are there to revisit policies/decisions once new information relevant to the question(s) emerges? How does this new information influence the policy/decision?

Operations, Emergencies, and Outcomes

Operational Level

Operations may be regarded as occurring on three levels:

Macro Level: Highest level—the federal and provincial governments. Everyday operations are shaped by departmental or agency mission or value statements, e.g., the Nova Scotia Department of Health Mission Statement. Macro bodies provide support and resources to other levels and develop and implement policies.

Meso Level: Mid-level—district health authorities and institutions or organizations such as long-term care facilities, hospitals, residential care facilities, clinics, and paramedic services. Most meso-level institutions possess codes of ethics or institutional value statements.

Micro Level: The individuals (health-care professionals and workers) working on the front line: physicians, nurses, paramedics, public health workers, laboratory workers, and custodial services. Often guided by professional codes of ethics (e.g., CMA, CCRN code of ethics), institutional codes of ethics (i.e., hospitals or clinics), or organizational codes of ethics.

Regardless of the operational level, the process should be fair, informed, open (transparent), accountable, and responsive.

The Dilemma Faced: Emergency Situations

Do values change during an emergency situation? Before addressing this question, what constitutes an emergency must be explained.

Gert (2005) has proposed three criteria that are necessary for an event to be considered an emergency. There must be

- an expectation of serious harm
- an expectation that someone can do something to prevent or reduce that harm
- time pressure

Clearly, a pandemic influenza fulfils all three criteria. Having established what an emergency is, how do values change during an emergency? In short, values and principles do not change during an emergency, although the applicability and relative weight of values may change. “The same basic morality applies to any human interactions. But when the same rules are applied in different contexts, different conclusions result.” (Gert 2005)

During a public health emergency, the focus will shift from the individual to the population. Therefore, in addition to caring for individual patients, health-care workers must also consider the public interest and the common good. Adherence to national recommendations regarding vaccine and anti-viral prioritization will be essential to ensure consistency and fairness across the country. This will enable a collective effort to work towards the primary goal of the Canadian Pandemic Influenza Plan: “to minimize serious illness and death, in the event of an influenza pandemic.” (PHAC 2006)

Upshur (2002) has proposed four principles for the justification of public health interventions:

Harm Principle: “The only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant.” (Mill 1859)

Least Restrictive or Coercive Means: The least restrictive or intrusive option that can accomplish the goal should be adopted. Should such means fail, then more restrictive options may be considered.

Reciprocity Principle: Reciprocity requires that institutions and society support those who face a disproportionate burden in protecting the common good and the public interest.

Transparency Principle: Decision-making processes should be open and transparent, with appropriate interests being represented at the decision-making table.

The Desired Outcome—Ends and Goals

Associated with ends and goals are inherent terminal values.

Ends are ideally established at the highest operational level—the macro level. Ends are more philosophical and ambitious in nature, e.g., a just society (egalitarian principles of justice), equality of access, and outcomes.

Goals are set at the macro-, meso-, and micro-operational levels. Policy goals should work towards achieving the ultimate policy ends. A goal/priority-setting tool is included in Appendix B.

What Is the Ultimate End of the Policy or Decision?

Too often policies are single-occurrence policies that do not achieve a higher purpose. Without an end, there is nothing to ground the goals. Until you know the end, you cannot know a fair process or procedure to achieve the end. Lack of an end may result in the formulation of inconsistent and conflicting goals at macro, meso, or micro levels. Therefore, policies and strategies should be crafted to achieve the goal of the Canadian Pandemic Influenza Plan. **For a more detailed framework description, see Appendix ?.**

Challenges to Be Faced

A pandemic influenza will have an impact on virtually every aspect of society. The health-care sector and society at large will suffer from shortages of both human and material resources. Effective planning will mitigate some shortages; e.g., stable items can be stockpiled, and human resources may be redeployed where needed. Communication will be key to the success or failure of any contingency plan. Accurate, up-to-date information will have to be disseminated to front-line health-care workers and the public. Health-care workers will need to know the epidemiology of the virus, modes of control and containment, and the current prioritization lists (e.g., vaccine and anti-virals). The public will need to know what they can do to prevent infection and where to go to receive vaccines/drugs and treatment. Yet, pandemic influenza cannot come to dominate the health-care agenda. Cancer, strokes, and other ailments will persist, and the delivery of health-care services cannot cease due to a pandemic.

We can prepare for the known knowns, the things we know we know: e.g., scarce resources and shortages of human resources. We can anticipate the known unknowns, the things we know we don't know, such as vaccine and drug prioritization based on unknown virus epidemiology. Perhaps the greatest challenge will be the unknown unknowns, the things we do not know that we do not know. Other than acknowledging their existence,

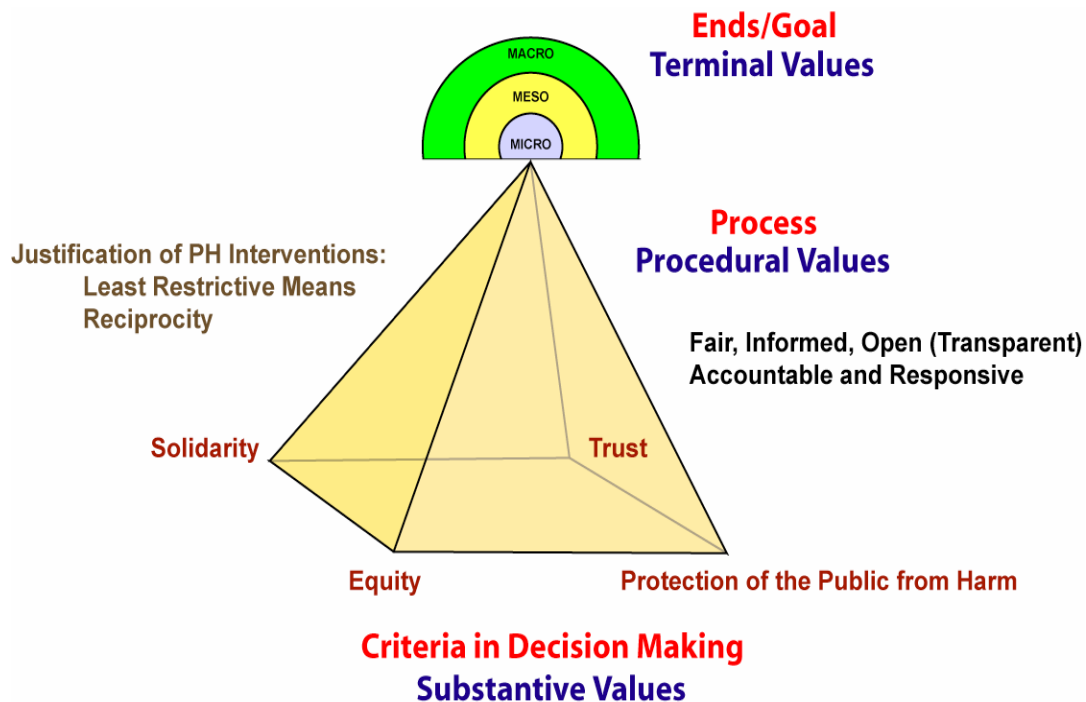
little can be done to prepare for the unknown unknowns; however, the implementation of comprehensive contingency plans, including communication strategies, should promote an effective response.

Integrating the Ends/Goals, Process, and Criteria in Decision Making

The four substantive values (protection of the public from harm, equity, trust, and solidarity) compose the criteria upon which judgments are based (at the base of the pyramid).

To achieve the ends/goals, a fair, informed, open (transparent), accountable, and responsive procedure (on the right-hand side of the model) is necessary to build and maintain trust, solidarity, and equity and to protect the public from harm.

For public health interventions, two additional principles are highly relevant: least restrictive means and reciprocity (on the left-hand side of the model).



Scarce Resources Example

(See Appendix C for other examples)

Dr K is a physician working in a rural hospital. Many of the patients seeking care at this hospital are elderly and have underlying health complications. The hospital possesses only three mechanical ventilators. Most days there are no emergency situations, yet all ventilators are in use. During annual influenza seasons, medical staff observe an influx of patients who present with respiratory complications requiring ventilation. Given Dr. K's extensive experience working in this small community, Dr. K. knows that a pandemic influenza will result in an influx of patients requiring ventilation. Dr. K must now make a decision about who will be ventilated.

Application of the Framework

(Note: Currently a tool is being reviewed across the health system in Nova Scotia that will further build capacity in the application of the framework.)

Understanding that the context of the situation is a pandemic emergency, the following questions should be explored:

What Is the Nature of the Policy Issue?

What role do I have in the situation presented? What are my professional values? How do they relate to the present situation, and how do they inform my professional position?

Is there anything about this issue that makes it unique? What information do we possess, and what information will be needed, to effectively address this issue? In the case of scarce resources, are there hospital policies on how to best utilize them during emergency situations? If so, are these policies applicable to mechanical ventilators during a pandemic? If not, can the existing policies be modified to address the issue? Alternatively, this issue will have to be addressed for the first time.

Can Dr. K deal with this issue on her or his own? If not, who else should be consulted? Procedurally, Dr. K should assemble a group of individuals to discuss the issue. Who should be involved in the discussion? Who has an interest in this policy? Ideally, Dr. K will assemble individuals who are familiar with mechanical ventilators and their everyday use and individuals familiar with influenza viruses and other infectious diseases. These individuals should include physicians, nurses, hospital administrators, and other

institutional staff who have a stake in this policy. Other individuals who will be most affected by the decision must also be considered. They should have a place at the decision-making table. They should be those who will represent the interests of patients (both infected and uninfected) and the public.

Once the stakeholders have been identified and the appropriate information (related to the virus and logistics of mechanical ventilation) has been circulated, a meeting should be convened—fair, informed, open (transparent), accountable, and responsive.

What is the ultimate end of the policy? In considering this question, one must be aware of the common good and the public interest. This end will shape the specifics of the policy. The process must be fair, informed, open (transparent), accountable, and responsive (i.e., representative of the stakeholders) and based on timely information; it must be recorded (a record of events); and there must be a way to revisit the policy should new information emerge. The inclusion of individuals representing the values of the stakeholders will ensure that all perspectives are represented.

What criteria should be applied to the policy? Have the values of patients, physicians, nurses, departmental managers, and other relevant stakeholders been considered? How have they been considered?

Appendix A: Definitions of Substantive Values (Criteria)

Policy Values

Policy Issues

Necessity/need: Lack of something important or essential. How is the proposed program or policy essential? What immediate action is required? How will this decision have an immediate impact on the health of the public or the delivery of health services?

Urgency: Call for haste or immediate action. Reflects an immediate need.

Relevance: The policy or decision must be relevant and consistent with the ends or goals.

Accountability: Responsibility for decisions/policies. Who is accountable for the decision or policy? What mechanism is there to ensure that there is accountability?

Policy Outcomes

Efficiency: Produce desired outcome with a minimum effort—simple, economical solutions.

Effectiveness/efficacy: Ability to benefit. Who will benefit from the proposed policy or decision? Who will be harmed? How effective is the proposed strategy or policy?

Feasibility: Capable of being achieved. Is the proposed policy realistic? If the proposed policy is unrealistic, it should not be accepted.

Acceptability: Satisfactory or acceptable. How acceptable is the proposed intervention to the public? to health-care professionals? Unacceptable decisions or policies may undermine public trust.

Quality: The degree of excellence of a thing.

Proportionality: Any measures taken to protect the public from harm that may infringe upon individual liberty should not exceed what is necessary to mitigate the danger or address the risk.

Sustainability: Policies or decisions that are not sustainable should not be considered.

Value for money: The ends must justify the means. Interventions or strategies beyond economic realities are not feasible.

Least restrictive means: During a public health emergency, individual liberty may be impinged upon to protect the public. If such measures are taken, policies that restrict individual liberty the least, while maximizing positive outcomes, are the most desirable.

Social Values

Justice (fairness)

Equity/equality: All Canadians have an equal right to health care.

Equity of access and outcome: Similar to equity/equality. Equity should apply to access to health-care resources and outcomes.

Universality: Equally applicable to all. Does the proposed policy effect/benefit all? Will some benefit more than others?

Social responsibility: Duty of the citizen to society. How far does social responsibility extend? Do all individuals bear equal burdens in society? What is the interplay between what one gives and what one receives from society?

Protection of the vulnerable or marginalized/protection from undue stigmatization: Variations of “protection of the public from harm.” During public health emergencies (e.g., outbreaks of infectious disease), it may become necessary to impinge upon individual liberty to protect the public from harm. Although circumstances may dictate the necessity of impinging upon individual liberty, individuals, communities, or groups must be protected from undue stigmatization. Particular attention should be paid to the vulnerable or marginalized, as they are more likely to suffer adverse effects from outbreaks of infectious disease and are less likely to seek medical attention (for any number of reasons).

Protection of human life: Self-evident.

Precautionary principle: Derived from the German word *vorsorgeprinzip*, which translates as “foresight planning.” Contemporary manifestations of the precautionary principle state that there should be a distinction between human actions and behaviours that cause “dangers” and those that cause “risks.” Governments should prevent dangers at all costs. In the case of risks, risk analysis should be carried out, and once the risk has been assessed, preventative action may be required.

Institutional/Organizational Values

Interdependence: Mutual dependence.

Solidarity: The notion that we are all part of a greater whole. For preventative public health strategies to be most effective, all individuals, communities, and groups must mutually support one another to enhance the probability of success. Global solidarity will be critical during a pandemic. All nations will have to co-operate and provide support to each other.

Duty to provide care: Health-care workers and professionals must weigh their professional roles and responsibilities against competing obligations to themselves, families, friends, and the community.

Stewardship: The notions of trust, ethical behaviour, and good decision making. Those entrusted with governance should be guided by the notion of stewardship. Stewardship implies that decisions should be made with the intent of achieving the optimal patient and public health outcomes.

Trust/fidelity: For a policy or decision to achieve the greatest success, there must be trust between all the stakeholders (e.g., the public and decision makers). Openness and transparency breed trust. Trust leads to acceptability. Without transparency and openness, one cannot have trust. Without trust, public acceptance of policies, guidelines, or strategies may wane.

Loyalty: Loyalty is related to trust and is important in building productive and lasting relationships.

Evidence: The justification of any policy or decision must be based on sound and complete evidence. In the absence of evidence, one should err on the side of caution (see precautionary principle).

Subsidiarity: If a small group or community can accomplish a task, then larger bodies (e.g., those at the macro level) should defer to the former. The role of the higher body will be to provide assistance and support. Decisions should be made as close as possible to the citizens that will be affected.

Individual Values

Liberty: Freedom, independence, exemption from obligation, the ability of one to decide for themselves. During public health emergencies, it may become necessary to restrict individual liberties to protect the public from serious harm. Restrictions to individual liberty should

- be proportional, necessary and relevant
- employ the least restrictive means
- be applied equitably

Freedom: Exemption from obligation. Independence.

Respect for autonomy: Demands that we respect and support personal choices made by “competent” individuals regarding their own health and health care, as long as these choices do not negatively affect others. In the context of infectious diseases, this principle requires that any measure implemented to prevent or control infectious diseases must be applied with the informed consent of the individual affected, unless some other, more “weighty” ethical obligation demands that the principle of respect for autonomy be overridden for a particular action (Kotalik 2002).

Privacy/Confidentiality: All individuals who enter the health-care system are entitled to privacy and confidentiality. During emergency situations, the right to privacy may have to be overridden to protect the public from harm.

Harm Principle/Protection of the Public from Harm: Health-care organizations, including public health ones, may be required to take actions that impinge upon individual liberty. Decision makers should

- weigh the imperative for compliance
- provide reasons for public health measures to encourage compliance
- establish mechanisms to review decisions

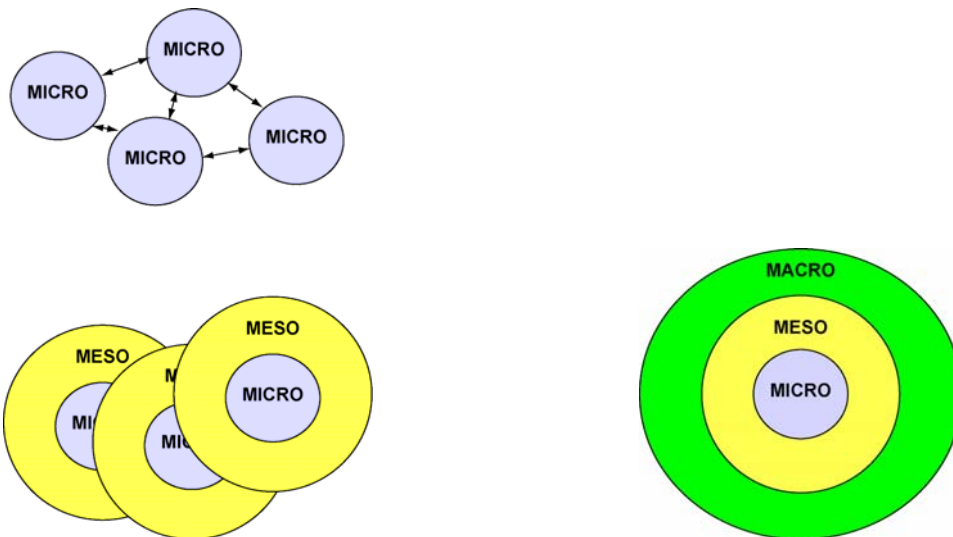
Dignity: An honourable quality, worthiness, high repute, or honour.

Appendix B: Goal/Priority Setting (Three Preliminary Steps)

Formulating and Contextualizing Ends and Goals

Ultimate policy ends should be established at the highest possible policy level, the macro-level (federal or provincial governments). The ultimate policy end should be more ambitious and philosophical in nature, e.g., a just society (egalitarian principles of justice). The ultimate end or goal of the Canadian Pandemic Influenza Plan is “to minimize serious illness and death, in the event of an influenza pandemic.” A secondary end is “to ease any social or economic disruption that might be caused by a massive outbreak of disease.” (PHAC 2006)

The primary aim of lower-level goals, at the macro (federal and provincial), meso (district health authority, institutional/organizational) or micro level (individuals working on the ground), should be to achieve the ultimate policy ends. In other words, the ends should help shape the goals. “One-off” micro policies without an ultimate end/goal may conflict (as shown below). Similarly, meso-level policies may also conflict in the absence of a macro end/goal.



Goal/Priority Setting

1. Identify parameters and pre-existing ends and goals within macro- and meso-level policies: Do they exist? If they do, are they applicable to the policy question at hand?
2. Analyse goal consistency across macro, meso, and micro levels: Are pre-existing meso goals consistent with macro goals and the ultimate end(s)? Are pre-existing micro goals consistent with meso goals, macro goals, and the ultimate end(s) of the policy question?
3. Defined goals if they do not exist. Alternatively, existing goals may have to be modified to correspond with meso-level goals, macro-level goals, and the ultimate policy ends. Similarly meso-level or macro-level goals may have to be modified to correspond with macro-level goals (in the case of meso-level goals) and with ultimate policy ends (in the case of both meso- and macro-level goals).

The most important question is, “What is the ultimate end or goal of this policy or decision?” Until one reflects upon the end/goal of the policy or decision, one cannot know what a fair process is, to achieve the goal. Lack of consistent and agreed-upon ends or goals may result in competing and conflicting policies. Without an end or goal, there is nothing to unite the many varied, disparate health-care functions and services. Ultimately, the process and criteria upon which the policy is based must map to the ultimate end(s) or goal(s). For a policy to be both relevant and consistent, the ends or goals must be explicitly identified, and the process must parallel the end or goal. Similarly, the criteria upon which one bases judgments must also be consistent with the end or goal.

What is the nature of the policy issue? Have priorities been established? Have policy/decision makers identified an ultimate end or goal for the policy/decision? What is the ultimate end? Is it for health policy? health-care policy? public health? How does this end affect different populations? What are the goals that will help achieve this end? Why is this particular policy or decision being discussed? Is it a single-occurrence policy only, arising from some pragmatic or political pressure, or is it part of a plan, intentionally directed to some larger end or goal? If it is a new issue, is it compatible with set priorities, or do priorities need to be revisited? How are the common good and public interest identified and protected in the consideration of various options? Will all benefit equally from the decision or policy, or will some benefit more than others? Is the intent to improve the health of some but not others? Will some be harmed by the decision or policy?

In addition to identifying the ultimate end or goal, one must also identify groups or individuals who have an interest in the policy question. Whose interests are being served by the policy?

Further Questions for Consideration: Goals and Priorities

What kind of society do you wish to achieve? a healthy Canada? an equitable Canada?

What are the ends/goals? What ought to be the ends/goals? Are the “is” and “ought” compatible?

Have priorities been established? Have the policy/decision makers identified or defined an overall end or goal for the policy/decision?

Is it for health policy? Health-care policy? Public health? Why is this particular policy/decision being discussed? Is it a single policy to address a single need arising from pragmatic or political pressure, or is the policy a single step designed to achieve a larger goal and the ultimate end? If it is a new issue, is it compatible with set priorities, or do priorities need to be revisited? How might the choice of different options facilitate or frustrate the larger ends or goals? How are the common good and public interest identified and protected?

How will this end or goal affect different populations? Will all individuals benefit equally, or will some benefit more than others? Is the intent to improve the health of some but not others? Will some be harmed by the decision or policy?

Appendix C: Scenarios

Preface

The following scenarios highlight a broad range of ethical issues and point to important values to consider in pandemic planning. RNs are among those most likely to provide direct care to ill patients and to implement public health measures. Thus, RNs are integral to the functioning of both the acute care and public health systems in Canada.

While a primary ethical issue related to health-care providers during SARS was the duty to care, this duty has been narrowly applied to individual health-care providers (University of Toronto Joint Centre for Bioethics Pandemic Influenza Working Group 2005). The duty of physicians has been the primary focus, with little attention paid to other professional health-care providers (e.g., RNs, physical therapists, occupational therapists, paramedics, and pharmacists), unregulated health-care workers, and support staff (e.g., dietary, laundry, and housekeeping staff). For nurses, the duty to care will raise difficult ethical concerns about risks to personal safety and the safety of their family and friends. What can be expected of nurses and other health-care providers in such emergency situations? Nurses face a significant degree of risk and injury from violence, infectious diseases, and stress in the course of their daily work. Not surprisingly, RNs have the highest rate of illness and injury among health-care providers. (O'Brien-Pallas et al. 2004) The Canadian Nurses Association *Code of Ethics for Registered Nurses* (CNA 2002) points to the duty to care to promote the well-being of patients, families, and communities. However, additional discussion is needed to elucidate acceptable levels of risk in relation to the duty to care. Health-care organizations also have a duty to adequately inform and educate staff about emergency contingency plans. They must also ensure that there are mechanisms for timely and accurate communication and sharing of information. Consideration needs to be given to issues of privacy and confidentiality in the sharing of patient information and in relation to local outbreaks to ensure timely deployment of resources.

Due to the increased age of the workforce, decreased intake in schools of nursing, and reduction of nursing positions, there have been nursing shortages in Canada. Shortages are expected to peak in 2015. Almost one-third of Canadian nurses work part-time; approximately 10 per cent work as casual employees; and approximately 12 per cent work for multiple employers. (CNA 2004) Concerns related to quality practice environments have been identified in Canada and abroad. (CNA and Canadian Federation of Nurses Unions 2004) While work is under way to improve practice environments, it is far from complete, and little attention has been given to the ethical analysis of quality practice environments and the implications for nurses in terms of enacting their moral responsibilities (Rodney et al. 2002; Varcoe et al. 2004). A key lesson from SARS was the need for health human resource planning in advance of a pandemic (CNA 2003).

As reported by the Canadian Nursing Association (2004), the majority of the nursing workforce is female (94.6 per cent). Many nurses must balance multiple, competing responsibilities, both professional and personal. This personal and professional burden of care may be greatest for RNs. During a pandemic, there will be an increased need for child care and financial compensation for those called upon to provide additional care. Therefore, the value of reciprocity is paramount in planning, particularly for those lacking short- and long-term disability due to part-time or casual employment.

Workload and stress on health-care staff will increase during a pandemic. Additional resources to support the implementation of measures will be required: e.g., nurses will require more time to educate, communicate, and support patients and the public. This speaks to the value of quality. Resources, both material (e.g., gloves and masks) and human (e.g., housekeeping staff), must be readily available. The current trend of contracting support staff (such as housekeeping) to private for-profit companies may raise issues of communication and duties. Support staff shortages will place additional stress and burdens on front-line health-care providers. It is ethically unacceptable for nurses and other health-care workers to bear such a burden in the face of insufficient human and material resources. The values of sustainability, accountability, and stewardship within the health-care system are fundamentally important in pandemic planning.

The National Pandemic Influenza Committee (PIC) makes recommendations based on the known epidemiology and pathogenesis of circulating influenza viruses when it comes to the prioritization and use of antivirals and immunizations. The primary means to achieve the Canadian Pandemic Influenza Plan goal and “to mitigate the impact of a pandemic is through immunization with an effective vaccine against the novel virus, and, to a lesser extent, through the use of antiviral drugs.” (PHAC 2006) The current PIC-derived prioritization list gives access of vaccines to front-line health-care workers. What is to be done when health-care workers refuse vaccination?

What follow are descriptions of two scenarios likely to arise during an influenza pandemic. The first case is a situation commonly encountered by nurses during day-to-day practice, but magnified during a pandemic. The second case explores issues related to a health-care worker/professional who refuses vaccination or prophylactic antivirals. Following each case description is a list of the values relevant to the case and a brief case description.

Case 1: Nursing Scenario

During an evening shift, a patient with a potential diagnosis of avian flu is admitted to an acute medical unit in a large urban hospital. The emergency department nurse who facilitates his transfer indicates that they have been alerted to expect other suspected cases. The man is admitted and placed in isolation. Little information is available concerning his

diagnosis, and the staff is concerned for their own safety and the safety of other patients. The unit manager has been involved in planning for such an event, but none of the staff on duty have received any education or information related to a suspected flu outbreak. The evening supervisor is called in to assist.

Ellie, a registered nurse (RN), is assigned to care for the patient. Ellie works part-time on the unit. She is a single parent of two school-aged children. Ellie also works as a casual employee in home care, providing her with more flexible working hours and extra income. Currently, she does not work weekends, as child care is not available. Ellie is concerned about her health, the health of her children, and the implications that an outbreak will have on her work schedule. This evening, the unit is short-staffed, and morale is low: one full-time RN called in sick, and again no replacement casual RNs were available. The unit manager has indicated that the unit is over budget for staff hours, and that staff must minimize use of supplies to balance the budget. Moreover, overall reductions in the health-care budget have resulted in bed closures throughout the hospital, and a consistent backlog of patients awaits placement in the Emergency Department.

This case illustrates that health-care workers will confront situations where harm may come to them, and in the case of infectious diseases, that there is the potential to infect close contacts. Is Ellie putting herself at risk by working in a facility with patients infected with influenza virus or other infectious diseases? Is Ellie putting her family at risk? Can Ellie trust that all measures will be taken to ensure her safety at work? Does Ellie have access to resources and information to address any questions or concerns that she may have regarding the risks she may face?

What values are at stake in Case 1?

Duty to provide care, stewardship, solidarity, reciprocity, trust/fidelity and accountability arise in this case. Other values that could also be considered include: evidence, equality/equity, social responsibility, liberty, and freedom.

Case 2: The Health-Care Worker Who Refuses Immunization

A new influenza virus is circulating around the world and has been detected in the community where Dr. M works. Dr. M works in geriatrics. Since Dr. M has daily contact with individuals considered to be at high risk for influenza virus infection, Dr. M is at the top of the vaccine priority list. Due to Dr. M's personal beliefs regarding influenza immunizations, Dr. M refuses to be vaccinated. What is to be done with Dr. M?

What Values Are at Stake in Case 2?

Liberty, freedom, respect for autonomy, efficiency/effectiveness/efficiency (ability to benefit), acceptability, necessity/need, urgency, proportionality, least restrictive means, equity/equality, equity of access/equity of outcomes, universality, solidarity, duty to care, stewardship, trust/fidelity, loyalty, evidence, value for money.

Discussion of Case 2

Clearly steps must be taken to deal with conscientious objectors, in particular those working in the health-care sector. How should they be dealt with? Should policy come from the macro, meso, or micro level?

Should Dr. M. be denied the right to tend to patients who may be ill (a risk to Dr. M's health)? Should Dr. M be denied the right to treat healthy patients (he may have had incidental contact with an infected individual)? Are there institutional guidelines in place to mediate these dilemmas when they arise?

The first question that one needs to ask is: What is the nature of the policy issue? Are there policies in place to deal with conscientious objectors, health-care workers, professionals and essential service providers who refuse immunizations? For example, are guidelines in place to deal with health-care workers or professionals who conscientiously object to immunizations or drugs? Such policies may be unique to institutions (e.g., hospitals and long-term care facilities), or they may be general and applicable to all facilities in a district health authority or province. If such policies do not exist, are steps being taken to draft policies? What is the ultimate goal of these policies or decisions? Who is responsible for making such decisions? Who should be invited to sit at the table to make this decision or draft this policy? Will it be a hospital-specific policy, a district health authority policy, or a provincial policy?

Is the goal to ensure that all employees can continue to contribute to the health-care system during an emergency situation? Is the goal to protect patients already within the health-care system, or those entering the health-care system? Is the goal to protect the employee? Can a goal be defined that encompasses all of these questions?

Once the goal has been defined, how should the process proceed towards the defined end? Again, the procedure should be fair, informed, open (transparent), and accountable. Moreover, in this instance, the procedure should also be responsive, and adaptable as new information emerges regarding the use of drugs and vaccines. For example, a vaccine may not yet be available, and there may not be enough antivirals to use in prophylaxis (priority for antivirals is for the treatment of infected individuals).

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