

Pandemic Flu Planning in the Community: What Can Clinical Ethicists Bring to the Public Health Table?

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It is still remarkably difficult for public health officials charged with developing and implementing pandemic influenza preparedness plans at the community level—where care is delivered—to obtain clear, concrete, and consistent guidance on how to construct plans that are both ethical and actionable. As of mid-2007, most of the federal and state pandemic plans filed with the Centers for Disease Control and Prevention, describing how public health officials will coordinate public agencies and private entities in the event of an outbreak, failed to include ethical guidance for first responders responsible for providing essential services and making fair decisions during a public health emergency. A survey of these plans, published in the *American Journal of Public Health* in June 2007, noted that planners were following a federal template that did not require them to be specific about *how* their plans met the test of public health ethics during a disaster: preparing first responders to act fairly when forced to think differently about their duties and priorities within their communities.¹

Some planners, in state departments of public health, in the nation's 3066 counties, and in private entities such as state hospital associations, are becoming aware that there is a moral and practical gap in the plans they are charged with carrying out. If these

plans are not candid about the ethical challenges first responders will face, and if these plans do not provide clear rules and tools for first responders to use once a state of emergency is declared, the burden on these front-line workers will be increased, and poor, crisis-driven decisionmaking may result.

But where can planners—specifically, public health officers responsible for coordinating health and safety services and public health educators responsible for providing community members with information about how to use these services—turn to ensure that their plans are both ethically sound and will work in practice? How can they avoid the tendency to lean on abstractions (“rationing,” “justice”), or to shift hard yet foreseeable decisions onto the shoulders of frontline workers? How can they learn how to anticipate and discuss foreseeable ethical challenges and to prepare first responders to make ethical decisions when, inevitably, unanticipated dilemmas arise? And how, when discussing pandemic planning scenarios in public forums, can they acknowledge and overcome the mistrust created by what has been described as a “post-Katrina consciousness” of health and health-care disparities among Americans?

The short answer would seem to be “bioethicists.” Recruiting the chair of

the ethics committee at a local hospital or a staff or consulting clinical ethicist if such a professional is available might be the best way for pandemic planners to fill this gap. But are clinical ethicists prepared to introduce public health officials to public health ethics? In a 2006 article describing the potential benefits of including bioethicists in pandemic planning, authors Jessica Berg and Nicholas King of Case Western Reserve University also described several potential “pitfalls” of doing so (p. 4).² If bioethicists do not grasp the basics of epidemiology, cannot think in terms of populations, or understand the logistics and special stresses of providing health and safety services during a disaster while simultaneously educating community members about what they should—or must—do to help the community survive, bioethicists will not be ready to fill the ethics seat at the public health planning table.

Clinical ethicists who have been involved in successful pandemic planning efforts echo these concerns: If we can’t make the transition from the clinic to the community, if we reduce “ethics” to “individual values and preferences,” or if we suggest that any rationing scheme will fail or be unjust, we simply will not be much use to public health officials who are looking at epidemiological models—and looking to us for help in framing and discussing basic questions about fairness, duty, and survival across an entire community.

So what *can* clinical ethicists bring to the pandemic planning table?

- **Rules and tools.** Clinical ethicists tend to have experience in writing guidelines for use by healthcare professionals, including clinicians and administrators. They also know how to discuss cases, lead grand rounds, and develop other

ways to help healthcare professionals sharpen their ability to spot ethical dilemmas, apply ethical guidelines, and make ethically sound decisions in complex situations. If clinical ethicists can first ensure that they understand how public health ethics—in particular, ethics in disaster situations—differs from everyday clinical ethics, they can use their clinically honed skills to help construct practical plans that are ethically sound and to train first responders.

- **Models.** Pandemic planning has been a highly fragmented activity to date. The absence of a universal healthcare system on which to build a consistently visible national pandemic plan can result in a silo effect: Communities or states that would likely be affected by the same outbreak of a contagious disease wind up planning in isolation from one another. “Home rule” traditions and regional rivalries can also impede public health planning between institutions and communities that will, in the event of an outbreak, undoubtedly need to work together. Clinical ethicists and ethics committee members have the potential to help their communities avoid duplication of effort and promote necessary collaborations by reviewing existing models for discussing ethical concerns, writing guidelines, and soliciting public comments; bringing good models to the attention of pandemic planners; and demonstrating how these models can be adapted for local use.³

Clinical ethicists can bring one more thing: the conviction, borne of experience, that diverse groups can learn how to discuss complex, controversial, even terrifying dilemmas, and to draw on these discussions to address current

problems and to prepare themselves for foreseeable challenges. With respect to pandemic influenza, these discussions must happen now, while there is still time.

Notes

1. Thomas JC, Dasgupta N, Martinot A. Ethics in a pandemic: A survey of the state pandemic influenza plans. *American Journal of Public Health* 2007;97(Suppl 1):S26–31.
2. Berg J, King N. Strange bedfellows? Reflections on bioethics' role in disaster response planning. *American Journal of Bioethics* 2006;6(5):3–5.

3. For examples of such models see "Promising Practices: Pandemic Preparedness Tools," a project of the Center for Infectious Disease Research and Policy (CIDRAP), funded by The Pew Center on the States. The "Promising Practices" web site includes an annotated, peer-reviewed list of pandemic planning resources that include significant attention to ethical issues: available at <http://www.pandemicpractices.org>. See also Berlinger N, Moses J. The five people you meet in a pandemic—and what they need from you today. *Bioethics Backgrounder*, November 2007, available at <http://www.thehastingscenter.org/backgroundunder-flu-pandemic.asp> or through www.pandemicpractices.org.