

Recovering from a Flu Pandemic

For Hospitals, Recovery Can Be as Demanding as the Event Itself

The anticipated arrival of a global influenza pandemic has spurred discussion of ethical issues related to it. Once a flu pandemic occurs, it will force hospital leaders to make difficult decisions—concerning, for example, which patients should and should not be admitted to critical care services that are already over-run. Such decisions are inherently values-based decisions, and are therefore ethical in nature.¹ Even decisions concerning when and how best to communicate with the public about the crisis (including disclosure of possible plans to cope with it) involve ethical considerations.

If hospital leaders are to make good decisions when the time comes, they should begin preparing for them now. Among other preparations, they should begin thinking about *pandemic recovery*—that is, about what happens six months or more after the crisis is over.

The fact is that hospital staff members will find themselves making very personal, sometimes anguish-filled decisions at the height of a pandemic. They must, for example, decide whether their first loyalty is due to their work or to their families. Intensive care unit (ICU) nurses who have young children at home may question their duty to care for seriously ill patients, knowing that, by doing so, they risk exposing both themselves and their families to the illness. On the other hand, ICU nurses have freely chosen and assumed the risks of their profession and are counted on by the public to lend their specialized knowledge to the treatment of sick patients.

Should failure to work under such circumstances be deemed insubordination and, therefore, grounds for dismissal? How does the organization reconcile different responses to crises by different staff members? Shouldn't an organiza-

tion that puts such a great emphasis on extending care and compassion to patients extend that same care and compassion to its employees?

Questions like these deserve the same diligent attention as those concerning other aspects of pandemic preparedness. Once the worst of a pandemic is over, health care organizations must pay attention to the long-haul goal of rebuilding *trust*, both in the community and among their own staff members. The extended recovery efforts may raise the most challenging ethical issues for the organization to sort through.

TRUST ISSUES

An organization's ability to rebuild trust is contingent upon the quality of the relationships existing among its staff members *before* a crisis strikes. No amount of strategic planning, motivational speechmaking, or convening of town hall meetings can recapture what never existed in the first place. Trust must be earned. Pandemic preparedness is one way to strengthen trust among employees and the public alike. This is done best by providing transparent, detailed operational planning that equips organizations with the resources—and thus the confidence—to respond to the pending crisis.

In Canada, Alberta is known as one of the provinces most prepared to deal with a pandemic. Alberta has worked to develop broad-based, trusting, and cooperative relationships among key stakeholders at all levels of government, hospitals and regional health authorities,* and social service agencies.

Preparing for a pandemic can itself foster the formation of trusting relationships, especially given the urgency with which contingency plans



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*Caritas Health Group is funded by the provincial government through Capital Health, one of nine regional health authorities in Alberta. Most provinces have these health authorities, which are ultimately responsible for the provision of health services to the community.

must be ramped up. There are good reasons to be prepared. History teaches us that pandemic influenzas strike as frequently as three to four times a century; and health care experts tell us that North America is overdue for such an event. The experts say that the question is not *if* but *when* the expected pandemic will occur.²

THE FACE OF PANDEMIC FLU

What does pandemic flu look like? Of course, most people experience influenza at some time during their lives. Symptoms include sudden onset of fever, extreme fatigue, general malaise, upper respiratory congestion, and cough. New strains of flu appear regularly and circulate in the community, most notably between November and April. During the annual flu season, hospitals see increased admissions, particularly among the frail elderly, and increased deaths.

Because most flu strains vary from each other only in slight ways, people who have acquired a degree of immunity through previous exposure to a similar strain become less ill than others. The variability of strains is also the reason why a new vaccine is required each year. Sometimes, though, a strain appears that is significantly different than earlier strains. The population, having had no previous exposure to it, is unprotected by immunity. The virus spreads very efficiently and rapidly, and large numbers of people become infected. When this occurs in multiple countries, we have a pandemic.

Influenza is transmitted by droplets of fluid or physical contact, not by an airborne mechanism. It is spread through, for example, shaking hands, improper disposal of a used tissue, and coughing or sneezing. The spread of any strain can be controlled to some extent by good hand washing, covering the nose and mouth when coughing and sneezing, and proper disposal of discarded tissues. Annual vaccination against the flu is advisable because it is thought to offer some protection during a pandemic outbreak of a variant strain.

When the expected flu pandemic occurs, it will come in waves, each lasting six to eight weeks, the second wave coming as soon as three months after the first. Vaccines will take three to four months to develop. Estimates are that 30 to 50 percent of the population may become clinically ill. There will be shortages of vaccines, antivirals, hospital beds, equipment, and skilled staff. Essential services in the community will be disrupted, and public gatherings may be banned. Businesses may be unable to operate, and, as a result, some goods and services will not be readily available.³ All of this will take place under unremitting public and media attention.

In Alberta, it is estimated that 500,000 to

1.3 million people will become ill during such a crisis. Of those, some 216,000 to 617,000 will require outpatient care. From 5,600 to 13,000 people will require hospital admission, and between 1,100 and 2,600 will die. Given the resource challenges that already confront the province, these numbers—conservative figures at best—are overwhelming.

Planning to meet the expected crisis in Alberta is under way at multiple levels of government, various agencies, nongovernmental organizations, and health authorities. All involved in the planning are following similar formats and have similar approaches. The planning concerns three phases: pre-pandemic, pandemic, and post-pandemic. Although the province's health authorities have devoted much attention to the first two phases, they have paid much less attention to the post-pandemic recovery period.

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As noted, Alberta is relatively well prepared for a flu pandemic. If, however, it has done less to get ready for pandemic recovery, the same is probably true for other Canadian provinces and for the United States.

BEGINNING THE CONVERSATION

Given the fact that the anticipated flu pandemic will touch the lives of millions of people, planning for it should extend beyond emergency preparedness committees and senior health officials. As we said earlier, many of the decisions to be made concerning a pandemic are ethical in nature. To prepare for them, hospital leaders and clinicians should educate themselves about the ethical principles upon which their policy decisions are based, identify the operative values inherent in those decisions, and prepare to publicly defend the decisions from a moral standpoint.

This is especially true for Catholic hospitals. Leaders and clinicians of such organizations must not wait until the first wave of flu occurs before they become knowledgeable about the ethical principles involved.⁴ Gaining the necessary knowledge will undoubtedly require answering questions such as that noted at the beginning of this article: What is the Catholic hospital's just response to employees who choose not to return

to work for fear of their own health and safety? Unfortunately, neither this question nor others—including some that involve basic assumptions—are getting enough attention at present.

This is a mistake. Unless hospital leaders begin a candid discussion of policies to be followed during post-pandemic recovery—a discussion that includes input from the people most likely to be affected by the policies—they will find that rebuilding trust and recovering solidarity after a pandemic is difficult.

PLANNING AT CARITAS HEALTH GROUP

Caritas Health Group, which comprises two acute care hospitals and a continuing-care center, is located in Edmonton, Alberta. At Caritas, we have slowly begun to educate our staff about pandemic recovery. Starting with our management group, and later with our frontline staff and physicians, we convened group discussions regarding the need for a strategy for dealing with the complex issues sure to arise during a pandemic.

What is the Catholic hospital's just response to employees who choose not to return to work for fear of their own health and safety?

Facilitated exercises have been helpful. In these exercises, small groups of staff members work through a number of possible pandemic scenarios. In one such scenario, we ask the group to imagine a hospital department in which 30 percent of the staff is sick, quarantined, or at home caring for family members. How could such a department operate successfully? Should it perhaps reinstate former staff members who have been dismissed for one reason or another?

Some group participants responded to this question pragmatically, saying that reinstating such staffers would depend on the reasons why they had been terminated. Others took a more principled approach, saying that it is never right to bring back an employee who has violated the hospital's trust.

Arguably, an employee who steals paper supplies for his or her children at the beginning of a school year is guilty of a smaller breach of trust than one who sexually abuses a patient. Still, the question about reinstating terminated staffers is a good starting point in encouraging staff members to examine possible policy decisions through an ethical lens, recognizing that different people will approach ethical decision making from different perspectives.⁵

During these exercises, we used another sce-

nario that deserves mention. Imagine, we told group participants, that a hospital staff has been fitted for high-quality face masks in anticipation of a pandemic involving a strain of virus that has a risk of airborne contamination. When the pandemic actually occurs, however, the planners, having learned that the high-quality masks are unnecessary, give the staff masks of lower quality. Such a switch would naturally raise huge trust issues. In discussing this scenario, group participants came to see that much of their work during a pandemic would involve trying to alleviate fear resulting from inadequate communication.

More difficult questions concerned employee behavior during a pandemic. We asked participants to consider what the hospital should do if an employee—for example, a respiratory therapist who fears exposing him- or herself to the flu virus during deep patient suctioning—were to refuse to come to work.

What should be the Caritas way of dealing with this situation? Does Caritas even have a policy to address such a situation? Would the hospital's leaders rely on the *Health Ethics Guide* (the counterpart, in Canada's Catholic health care, to the *Ethical and Religious Directives for Catholic Health Care Services*), which acknowledges an employee's right to conscientious objection? "No one may be required to participate in an activity that in conscience the person considers to be immoral," the guide says.⁶ "While continuing to fulfill its mission, the organization is to provide for and to facilitate the exercise of conscientious objection without threat of reprisals. The exercise of conscientious objection must not put the person receiving care at risk of harm or abandonment."

Or should the hospital emphasize another statement, found in the same section of the *Health Ethics Guide*, which reminds staff members that they have a duty not to abandon their patients? Where does one's moral responsibility begin and end?

At present, we do not yet have a very clear sense of how we will respond to a staff member's refusal during a pandemic. Caritas has had recent experience with outbreaks of a gastroenteritis-causing norovirus and, as a result, has developed a policy to address attendance and safety issues and reassignment options. But these norovirus outbreaks were limited. The sheer magnitude of the anticipated flu pandemic brings with it new levels of uncertainty. And this uncertainty underscores the importance of asking the questions now.

There are other pandemic-related ethical issues that require discussion. For example, it has been noted that, during the 2003 SARS (severe acute

respiratory syndrome) crisis in Toronto, some hospital employees, having previously exhausted their sick-leave benefits and fearing loss of wages if they were not allowed to work, neglected to report their own symptoms of illness, including exposure to people infected with SARS. To prevent such occurrences in Alberta, a policy is being considered that would urge employers to pay health care workers who remain at home when they fall ill; such a policy would help contain the spread of pandemic disease. The provincial government has also recently introduced legislation to prohibit termination of employees.⁷ A report from the University of Toronto's Joint Centre for Bioethics adds a more sober recommendation for staff members and their families who are significantly affected by influenza while discharging their duties. The center recommends that the government and the health care sector take financial responsibility for their disability insurance and death benefits.⁸

The challenge remains: Who will look after patients if health care workforces are depleted because staff members themselves are ill, quarantined, or taking care of family members at home? What of a hospital's basic ethical duty to provide care?

PRACTICING RECOVERY

Caritas recently participated with other organizations in the region in a large-scale pandemic exercise. One of the questions discussed was this: If our ICUs were overrun and we had to ration resources, would we be prepared to restrict care to those patients who are severely ill? Assuming that the answer was yes, would we be transparent in communicating our decision to the community? Would we stick to this decision if we felt pressured to deviate from it? This last question is significant because, although stories about mass tragedies appear in the news frequently, the human mind cannot appreciate the enormity of the numbers of casualties reported. What can the tens of thousands of people who annually fall victim to the world's natural disasters mean to the rest of us? How do you put a face on such numbers? The situation would be very different, however, if we had to restrict known staff members or their families from the ICU.

A prayer written for the occasion reminded exercise participants that we deal with one patient at a time. This realization is both comforting, and disturbing. Consider what happens in a triage situation, for example. Caregivers are comforted when, facing a number of severely ill or injured patients, they can focus their skill on the one they know they can save. But they are disturbed when

they must triage a patient to the side in order to treat another who happens to have a better chance of survival. In the exercise, we asked ourselves how consistently would we apply clinical triage criteria if one of our staff members were among the severely ill or injured. Would public trust in Caritas be broken if, in a triage situation, we were to treat board members, politicians, or senior hospital executives differently than we treated other patients?

Of course, it is one thing to engage in detached ethical reflection in an exercise. It is another thing altogether when one must look into the face of a patient one has just sidelined in a triage, or respond to a reporter who asks whether some patients may be receiving preferential treatment.

WHY IS IT IMPORTANT TO PLAN?

Although medical authorities are generally agreed that a flu pandemic is inevitable, planning for it in North America is far from seamless. Many organizations lack the resources necessary to prepare for it. Others are reluctant to secure resources for what they see as an event "that may never happen," especially when current needs are not being met. In many cases, the person assigned to direct pandemic planning already has a full-time role to fill and, consequently, gives the planning less than his or her full attention. In other cases, the person given the job may have little expertise in emergency preparedness.

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Even hospitals possessing solid, comprehensive pandemic plans will find that communicating those plans to their staffs and others will be a challenge. On hospital staffs, gossip and misinformation will inevitably serve to undermine trust and breed insecurity. Frontline staff members must be assured that their health and well-being will not be sacrificed in a pandemic and that their safety will be prized no less than that of senior leaders. But trust cannot be simply mandated. The transparency and genuineness in which key messages are delivered before and during a pan-

demic will largely shape recovery efforts afterwards. It is vital that staff members have an opportunity to talk in advance about likely scenarios, the ethical challenges, and the values that support the ethical framework according to which key policy decisions are made.

Addressing public concerns and communicating effectively with the community will be a challenge. The public always expects hospitals to conduct “business as usual”—even during a pandemic. However, once a pandemic occurs, “business as usual” will not be possible. At such a time, a hospital’s skilled staff may be reduced by as much as 35 percent due to illness or absenteeism, leaving patients to be cared for by less skilled staff. Standards of care will inevitably fall, and care itself could be rationed.

The problems caused by the pandemic will take a toll on both the hospital and the public’s trust in it. Public scrutiny will be intense. Consequently, once the crisis passes, the hospital’s leaders will find restoring public confidence in the facility to be a significant challenge. But rebuilding trust will be easier for them if they can demonstrate that the decisions made during the pandemic were consistent, reasonable, and morally defensible. On the other hand, behavior during the pandemic that seems to reveal a double standard of care—high-quality care for some people, low-quality care for others—will result in irreparable damage to the facility’s reputation. It is for these reasons that hospitals would do well to focus on pandemic preparedness now, including preparedness for recovery.

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Recovery involves reconciling people with each other, including those who work on the same hospital unit and have become estranged from each other because they reacted to the pandemic in different ways. One of this article’s authors witnessed an example of such estrangement following the SARS pandemic of 2003.

The author had journeyed to Toronto to

attend the annual conference of an international organization. The conference happened to coincide with the height of the SARS outbreak. Indeed, on the day the delegates arrived, the World Health Organization posted a travel advisory warning against travel to Toronto. As a result, many conference delegates were greeted at Toronto’s airport by reporters who asked if they weren’t afraid to be in the city. Obviously, some were. In fact, some delegates—and even some of the organization’s board and staff members—elected not to go to Toronto at all.

During a conference call a few weeks later, board and staff members talked about the Toronto conference. Participants in the call discussed who had—and who hadn’t—attended. Some of the latter expressed resentment at (as they saw it) being “judged” for their failure to attend. They had, the nonattenders said, been warned by the media of the risks involved in going to Toronto. They cited what were valid concerns of potentially exposing themselves or vulnerable members of their families (some lived with frail elderly people) to the SARS virus.

The conference call became an opportunity for its participants to clear the air of resentments and suspicions. This, fortunately, was made easier by the maturity, engagement, and commitment of the participants. But such reconciliation may not be so easily achieved in more complex situations involving much larger numbers of people—such as a hospital staff during a virulent pandemic. Resentments arising in that case might never be worked through. And confidence on the part of both the hospital staff and the public might be irrevocably shattered.

It is for this reason that hospital staffs should begin now, before a pandemic occurs, to talk about the moral options involved, about the responses different people are likely to have, and about being tolerant of those responses.

A CALL TO SOLIDARITY

The chief lesson learned from the Toronto outbreak is that health care leaders need to prepare their staffs for the various decisions they will have to make during the pandemic, when it occurs.

Questions concerning resources tend to figure most prominently in people’s minds—which patients, for example, are most likely to benefit from ventilators and beds in the ICU? But it will be the more subtle, less sensationalized issues that tend to linger on after the pandemic recedes. Recovery from a pandemic, like that from a protracted labor dispute, is generally a lengthy process. Once a bitter strike is over, time must pass before those who walked the picket line and

those who crossed it can be reconciled with each other. Something similar probably will happen after a pandemic. Time is a great healer of wounds, but organizations that fail to engage in the work of recovery will find that the wound is easily reopened.

The Christian notion of solidarity is helpful here. A presentation made during the 2006 Canadian Catholic Bioethics Institute conference in Calgary, Alberta, reminded participants of the need for mutual trust and solidarity in the community during a pandemic, given the number of personal decisions that will be made and then challenged afterward. We who work for health care organizations must be prepared to stand with, not over, those who will be making very personal, even haunting decisions during a pandemic. We must be courageous of heart and willing to suspend judgment, knowing that not everyone will understand or accept our decisions.

Pandemic flu illustrates the need for moral resiliency and imagination in trying to enter another person's decision-making process, and to respect it even if that person's decision conflicts with our own. Preparing for pandemic flu is more than planning, implementation, and execution. It involves learning about ourselves, about our values, and about how we—as individuals and as members of an organization—make ethical decisions. What is required is not just getting through the crisis but also recovering and learning from the experience. The crisis will certainly reveal our values in action, for better or for worse. ■

NOTES

1. See, for example, Ezekiel J. Emanuel and Alan Wertheimer, "Who Should Get Influenza Vaccine When Not All Can?," *Science*, vol. 312, no. 5,775, May 2006, pp. 854-855.
2. "Pandemic Planning: Capital Health Region Well Prepared to Meet Outbreak," *Capital Health Quarterly*, Fall 2005, pp. 8-9.
3. See *Alberta's Plan for Pandemic Influenza*, Alberta Government Health and Wellness, Edmonton, Alberta, November 2003 (www.health.gov.ab.ca/influenza/pandemic.html).
4. See Pandemic Influenza Working Group, *Stand on Guard for Thee: Ethical Considerations in Preparedness Planning for Pandemic Influenza*, University of Toronto Joint Centre for Bioethics, Toronto, Ontario, November 2005, p. 4 (www.utoronto.ca/jcb/home/documents/pandemic.pdf). The report's authors emphasize that the ethical framework for decision making must be transparent and constructed well in advance of the crisis.
5. See Brian O'Toole, "Four Ways People Approach Ethics," *Health Progress*, vol. 79, no. 6, November-December 1998, pp. 38-42, 43.
6. Catholic Health Association of Canada, *Health Ethics Guide*, Ottawa, Ontario, Canada, 2000, no. 139.
7. Pandemic Response Statutes Amendment Act, introduced March 12, 2007 (www.gov.ab.ca/acn/200703/211594794A47D-0196-4309-32F5CE66EA3BAFE5.html).
8. Pandemic Influenza Working Group, p. 12.

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