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for **Healthy Public Policy**

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CASE STUDIES | MARCH 2010

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ABOUT THE NATIONAL COLLABORATING CENTRE FOR HEALTHY PUBLIC POLICY

The National Collaborating Centre for Healthy Public Policy (NCCHPP) seeks to increase the expertise of public health actors across Canada in healthy public policy through the development, sharing and use of knowledge. The NCCHPP is one of six Centres financed by the Public Health Agency of Canada. The six Centres form a network across Canada, each hosted by a different institution and each focusing on a specific topic linked to public health. In addition to the Centres' individual contributions, the network of Collaborating Centres provides focal points for the exchange and common production of knowledge relating to these topics.

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INTRODUCTION

A key goal of Canada's National Collaborating Centres for Public Health (NCCPH) is to facilitate the development, sharing, and use of knowledge in public health, a goal which includes building and strengthening links among public health practitioners, researchers, and policy makers. The National Collaborating Centre for Healthy Public Policy (NCCHPP) produces different tools for understanding and improving public health policies and practices, and that enable public health actors to meaningfully contribute to diverse policy processes that influence population health. To achieve this, the Centre has set out to communicate knowledge and practical ideas from various disciplines to public health actors.

The discipline of moral philosophy has much to offer public health. This is perhaps nowhere more evident than when planning for and responding to widespread emergencies such as an influenza pandemic, which requires making difficult decisions under conditions of stress, uncertainty, and scarcity of resources. Mounting public and political concern to detect and control the spread of infectious disease outbreaks like severe acute respiratory syndrome (SARS) and avian and swine flu explains a large measure of the growing interest in public health ethics (PHE), a relatively new sub-field of applied philosophy that encourages interdisciplinary discussion of moral issues in the theory and practice of public health and preventive medicine. Emerging over the last 15 years out of dissatisfaction with the traditional orientations of biomedical ethics, PHE involves the explicit use of concepts from ethical and political theory to discuss and evaluate collective interventions that aim to protect and promote the health of groups and populations rather than of individuals. The importance of PHE to pandemic preparedness and response is difficult to overstate, as evidenced by the proliferation of ethical frameworks and decision guides in the academic literature and within national and international pandemic plans.

This collection of 11 case studies extracted from existing documents or research proposals is part of a larger project on ethics during a pandemic currently being undertaken by the NCCHPP, and is intended to contribute to one of our larger core objectives, which is to provoke reflection on the use of ethical analysis in public health practice and for the development of healthy public policy.

The general aim of this series of cases is to illustrate a wide range of pandemic and infectious disease control scenarios in which professional roles and responsibilities generate ethically complex situations. Covering issues related to the powers and duties of public health officials and health care providers, and designed to place ethical issues related to preparing and responding to outbreaks in practical contexts, the cases aim to assist in the development and application of moral reasoning through concrete examples. Such an overview of some of the most pressing moral issues and debates likely to arise during a pandemic is not meant to establish normative, definitive or absolute prescriptions by identifying a single good course of action.

These cases are instead meant to stimulate deliberation, or the in-depth discussion within a group of free and equal individuals (perhaps from multiple disciplines and potentially with dissimilar points of view) in order to gain a deeper understanding of the issues from different perspectives and in general and specific contexts. Deliberation may lead to consensus on a

preferable or acceptable course of action, notably through the identification, evaluation and comparison of alternatives. A commitment to mutual respect in the transparent search for shared interests is particularly encouraged, especially since clashes between different beliefs, interpretations, or justifications, each of which may be defensible from certain specific perspectives, are to be expected in light of the risks and uncertainties portrayed in the case scenarios.

Although values and ethical principles cannot be applied in mechanistic or linear ways to provide clear-cut answers to complicated questions such as those raised in this series of cases, they can stimulate thinking and provide guideposts to help both individuals and institutions make good decisions in difficult times. It is important to keep in mind that not all principles important in public health (which include at least the common good, solidarity, equity, reciprocity, necessity, protection from harm, proportionality, individual liberty and dignity, privacy, and effectiveness) or in good decision making (which generally requires that processes be reasonable, transparent, inclusive, responsive, and accountable) will always be relevant in every case.

It is also crucial to note that there is no widely accepted hierarchy of principles or goals for public health, which means that no single principle will always or even generally take priority when it comes to public health interventions or policies, which often involve balancing multiple objectives and values. Thus, each of the cases, like every situation or decision, is best approached as a unique constellation of circumstances that merit individual consideration. While there may thus be no objectively right answer to many of the moral challenges raised in these scenarios, there are justifiable answers for persons seeking to act in the face of any particular dilemma. Searching for and arriving at justifiable solutions, even if they are tied to specific contexts, is a key goal of ethical analysis, one that is central to the development of shared understandings of practical ethics. Ultimately, it is hoped that these cases will firmly demonstrate that to “do ethics” in a public health context is necessarily messy rather than formulaic, and that it requires work, time, and deliberation within and across communities.

THE CASES

Case 1: A physician's duty to care during a pandemic
Case 2: Canada's international obligations during a pandemic
Case 3: Priority setting on an ICU during a pandemic
Case 4: Social distancing measures, a mourning family, and pandemic control
Case 5: Suspected XDR-TB and international travel
Case 6: Developing quarantine guidelines for a busy port
Case 7: Researching TB among the urban homeless
Case 8: West Nile virus surveillance results
Case 9: Cross-border contact tracing
Case 10: A nurse's duty to care during a pandemic
Case 11: The health care worker who refuses to be vaccinated

The first four case studies, each of which presents a scenario unfolding over time much like during an actual pandemic, were developed by the members of the Ethics and Pandemic Preparedness: Engaging the Voices of the Public research group at the University of Toronto Joint Centre for Bioethics (JCB). Funded by the Canadian Institutes of Health Research (CIHR), this group conducted a national survey on ethics during a pandemic and held town-hall meetings in major cities across the country in 2008-09, at which the case studies were presented and discussed with a wide cross-section of Canadians. Results from the Engaging Voices project and from other related research as well as additional information are available at www.canprep.ca. Although the scenarios developed by the researchers have not been published or made publicly available, permission was granted to the NCCHPP to reproduce them in the slightly modified form in which they here appear.

Case studies 5 and 6 were extracted, with minor modifications, from a recent Teaching Note prepared by Drs. Ross Upshur and Angus Dawson of the JCB, for the Public Health Agency of Canada (PHAC). This document has yet to be published or made publicly available, although PHAC's Public Health Law and Ethics Program granted permission to the NCCHPP to extract the case scenarios from the report in question.

Cases 7, 8, and 9 were developed by professionals working in public health and have been taken from the summary report of a 2009 public health ethics workshop held at the JCB that was facilitated by Drs. Upshur and Dawson and sponsored by PHAC's Public Health Law and Ethics Program. This report has not yet been made public, but permission was granted to the NCCHPP to extract the case scenarios that are reproduced below.

Cases 10 and 11 appear in the Nova Scotia Health System Pandemic Influenza Plan Framework for Ethical Considerations and Decision-Making (2007), by Ryan Melnychuk.

Two much briefer cases in applied public health ethics for front-line practitioners, one related to confidentiality and contact tracing when routine testing reveals a sexually transmitted infection (STI) and another about a non-compliant homeless tuberculosis (TB) patient, are

available online from the University of Washington's School of Medicine: http://depts.washington.edu/bioethx/topics/public.html.

CASE 1: DUTY TO CARE SCENARIO

The media is reporting that the World Health Organization (WHO) has officially determined that a pandemic influenza is now underway. The Public Health Agency of Canada has confirmed person-to-person spread in several Canadian cities. The local media are reporting increased demands for emergency room and family physician office visits. Some deaths have been reported, but no one is really certain how serious the problem may be. Little is known about the actual virus at this point. Maria is a 35-year-old family physician and mother of three children aged 4-8. She works in a primary care clinic in Saint John and is one of 12 doctors practising in the clinic. Her husband, hearing the media reports, is concerned that she may become ill or bring home illness to her family because of the increased exposure at work. He encourages her not to go to work. Maria is concerned for the care of her children. They attend a day care centre. Her husband works in an accounting firm. She is also worried about abandoning her patients and increasing the workload of her colleagues, many of whom, like her, have young families.

First set of questions

- What are your initial thoughts and feelings about this?
- What do you think are the most important considerations for Maria in making her decision?
- Would your opinion change if the day care centre was closed? Why?

Maria decides she will go to work. She is concerned that her clinic lacks the appropriate amount of protective equipment. The clinical group meets and decides that they are committed to providing care to people with influenza, but will only do so if the ministry of health provides appropriate protective equipment.

- What do you think of the clinical group's decision?
- Do you think society has an obligation to health care workers in the event of a pandemic outbreak?

One of Maria's colleagues is close to retirement. He has diabetes and heart disease. He tells the clinic that he will not come to work as he feels the risk to his own health is too great.

- In your view, is the health status of a health care worker an acceptable reason not to respond to a pandemic virus?

The influenza outbreak is now well advanced. Many people are sick, including a large number of health care workers. Many health care providers in hospitals and clinics are not showing up for work. Many refuse to work because they fear infection.

- Should health care providers face consequences for refusing to show up for work?
- If no, why? If yes, what sorts of penalties do you think would be fair?

The government has now officially declared a health emergency. It is enacting legislation mandating health care workers to participate in the efforts to control the outbreak.

- What do you think about this possibility?
- Do you think such laws would violate the rights of health care workers?

Final questions

- In your view, is it justifiable for health care providers to refuse to provide care?
- Who should make these kinds of decisions?
- How should these kinds of decisions be made?
- In the absence of a consensus, how should these decisions be made?

CASE 2: GLOBAL GOVERNANCE AND OBLIGATIONS

Preparing and responding to an influenza pandemic requires organization and cooperation between countries as well as within them. Poorer countries will not be able to protect their citizens from this pandemic without help from wealthier countries, and wealthy countries cannot fully prepare for a pandemic without information from poorer countries. More specifically, before a pandemic, surveillance and the sharing of samples of new infections are vital in order to develop effective drugs and vaccines against emerging strains. For influenza, the culling of livestock in cases of confirmed or suspected infection is also necessary. There is also evidence that at the earliest appearance of a new pandemic, helping poorer countries respond to the outbreak while it is still small might be able to either stop it altogether or at least slow down the spread of disease, giving wealthy countries more time to develop an effective vaccine that experts feel will be the only way to beat a global influenza pandemic.

Initial scenario: pre-pandemic preparedness

Scientists from Canada and other developed countries are working to develop drugs and vaccines against a strain of influenza and they need samples from Indonesia. However, Indonesian officials are refusing to share the newest virus samples because of concern that the country will not be able to provide its own citizens with access to newly developed drugs/vaccines. The problem of access to drugs/vaccines in Indonesia is related to both the small initial world supply once they become available and to their high cost, which will exceed what many countries are able to pay. These problems are in turn related to a very limited global manufacturing capacity and the largely private for-profit development of such products. Following Indonesia's lead, other countries consider refusing to share flu information and threaten to stop testing and culling livestock, stating that they have more pressing human public health concerns and that wealthy countries must pay the full costs of monitoring for outbreaks and compensating for the resulting economic losses.

First set of questions

- What are your initial responses to this situation? (What is your gut reaction?)
- What are the most important considerations in this scenario?
- What are the features of this situation that you find the most compelling?

- Based on your discussion thus far, how should Canada respond to:
  - Indonesia's demands for more equal access?
  - The developing world's (poorer countries') demands for fairer public health investment assistance more generally?

The WHO tests some samples from rural Indonesia and confirms the emergence of a new strain of highly transmissible human influenza. Limiting travel may be effective in delaying the spread of the disease, although this remains uncertain. In addition, there is some evidence to suggest that if all countries share their anti-viral stockpiles, the magnitude of the outbreak could be reduced.

- Have your initial responses to the situation changed in light of this information?
- Are there any facts that you find significant in this latest piece of information?
- Is there anything compelling about this development?
- Based on your discussion thus far, how should Canada respond to:
  - The reduction or stopping of travel to and from Indonesia (consider economic costs/compensation and whether it will be fair to the Indonesians/Canadians)?
  - The request from WHO to release 10% of national stockpiles to contain the outbreak in Indonesia?

Imagine that the outbreak initially occurred in Canada, where the WHO tests some samples from Vancouver and Toronto and confirms the emergence of a strain of highly transmissible human influenza.

- Have your responses to the situation changed in light of this information?
- Are there any facts that you find significant in this latest piece of information?
- Is there anything compelling about this development? Does your perspective on this case, and on appropriate travel restrictions, international resource sharing, and compensation change when a pandemic emerges here and threatens to spread internationally, rather than the other way around?
- Based on your discussion thus far:
  - Should Canada be under any obligation to report/share information with the international community, even if it impacts the economy?
  - Should there be a travel advisory to and from Canada?
  - Who do you think should be primarily responsible for determining how the pandemic in Canada should be managed? Why?

Final questions

- What are Canada's global obligations before, during, and after an influenza pandemic, to whom are they owed, and why?
- Who should make these kinds of decisions?
- How should these kinds of decisions be made?
- In the absence of a consensus, how should these decisions be made?

CASE 3: PRIORITY SETTING ON AN ICU

Initial scenario

The Regional Hospital is a major trauma centre with a large emergency department and intensive care unit (ICU). During the outbreak of a pandemic influenza crisis, the ICU is filled to capacity with patients suffering from life-threatening medical conditions, including complications from influenza-like bacterial pneumonia. The emergency department calls the ICU seeking to admit Mr. M, who was brought to the emergency room with a severe but potentially reversible brain injury after a bicycling accident. One alternative is to move one of the current ICU patients to a medical unit in order to make room for Mr. M. However, the ICU staff reports that all of their patients need ventilator support, and there are no other ventilated beds available in the hospital. Another alternative is to send Mr. M to another unit in the hospital. However, given Mr. M's injuries, it is clear that this would overtax the clinical capabilities of the health care staff, who are not trained in critical care and who are already struggling to care for other patients. The final alternative is to transfer Mr. M to another health care facility. However, the influenza pandemic has overwhelmed all hospitals in the region, and there are no available ICU beds anywhere else.

First set of questions

- What are your initial responses to this situation? What is your gut reaction?
- What are the most important considerations in this scenario? Which ones are the most relevant?
- What are the features of this case that you find the most compelling?

An ICU patient passes away. There is now a bed available in the ICU for Mr. M. Just as his transfer is about to be made, an ICU nurse named Ms. A is admitted with severe difficulty breathing. It is determined that she has been infected with the influenza virus, which she may have contracted while caring for patients in the hospital's ICU. She needs immediate ventilation support, which is only available in the ICU bed designated for, but not yet occupied by, Mr. M.

- Have your initial responses to the situation changed in light of this information?
- Are there any considerations that you find significant in this latest piece of information?
- Is there anything compelling about this development?

It comes to light that Mr. M has aging parents at home who rely on him for help with activities of daily living. Ms. A is a longstanding employee of the hospital and is well respected by her peers at the hospital.

- Have your responses to the situation changed in light of this information?
- Are there any considerations that you find significant in this latest piece of information?
- Is there anything compelling about this development?
- Do these personal details about the two patients' lives affect your perspective on this case?

Final questions

- Who should be given the ICU bed: Mr. M or Ms. A?
- Who should make these kinds of decisions?
- How should these kinds of decisions be made?
- In the absence of a consensus, how should these decisions be made?

CASE 4: RESTRICTIVE MEASURES SCENARIO

The media is reporting that the WHO has officially determined that an influenza pandemic is now underway. The Public Health Agency of Canada has confirmed person-to-person spread in several Canadian cities. Some deaths have been reported, but no one knows yet how serious the problem may be because there is no information on the extent of the outbreak. Little is known about the actual virus at this point. Vaccine development is underway; however, large-scale public vaccination programs are not expected to be available for 6 to 8 weeks.

Initial scenario

Public health officials are strongly recommending the immediate implementation of some restrictive measures to help slow the spread of the infection. This includes the closing of community centres and the cancelling of all large public gatherings. One family whose 2 daughters, 24-year-old Amandeep and 16-year-old Marpareet, were killed in a car accident just as this information was released did not hear this information because it was disseminated in the English media and they do not watch TV or listen to the radio in English. Sponsored by Amandeep to come to Canada, Marpareet, her brothers, Rajinder and Darshan, and her parents arrived from India less than a year ago and speak little English. The family holds a large memorial service of family and friends the following day. Few people do not show up because most of them, although they had heard the order by authorities, think that the cancellation of large public gatherings means cancelling social events, not a funeral, which is a sacred rite to honour the passing of a loved one. Moreover, the tragedy of this untimely loss overshadows everyone's concern about an outbreak whose seriousness remains unknown. There have been no reported deaths from influenza in their immediate community. Over 200 people attend the funeral.

First set of questions

- What are your initial thoughts and feelings about this situation?
- What do you think were the most important considerations for the family in making their decision?
- What are the features of this case that you find most compelling?

Public health authorities issue an order requiring everyone who attended the funeral to stay home for a period of 7 days, even though there is still little information about the virus or the extent of the outbreak. Rajinder wonders whether this is feasible, as his family depends on his income. He decides to go to work stocking shelves at Canadian Tire, in spite of the order, while the rest of his family stays home.

- What do you think of Rajinder's decision?
- Do you think people should face consequences if they don't follow an order of quarantine? If yes, what sort of penalties do you think would be fair?
- Is there anything compelling about this development?

The government has now declared a state of emergency. Three people who attended the funeral are showing symptoms of influenza and one person has died from it. Although Rajinder is aware that the outbreak has now hit close to home, he can't see how it would be possible for him not to go to work. After failing to heed the order, public health officials detain Rajinder, meaning that his family is left with no income and stranded at home with little food.

- Have your responses to the situation changed in light of this new information?
- What do you think of the public health authority's decision to detain Rajinder?
- Do you think society has obligations to those ordered into quarantine?
- Is there anything compelling about this development?

Final questions

- How do you feel about the use of detention in the event of an outbreak?
- Who should make these kinds of decisions?
- How should these kinds of decisions be made?
- In the absence of a consensus, how should these decisions be made?

CASE 5: SUSPECTED XDR-TB

You work as a quarantine officer at a large international airport, serving a local multicultural population comprising many millions of people. One of your key tasks is to ensure and protect the health of all the people who pass through the airport, both incoming and outgoing, as well as the local population. One day you receive a phone call from a friend. She works for the city's Department of Public Health, with a particular responsibility for infectious diseases. She quickly explains that she has been dealing with a recent case of XDR-TB in an extended family, and is concerned that part of the family (two adults and two children) has actively avoided contact with her department in the past. Given the domestic situation, she believes that there is a reasonable probability that one or more members of the family may be infected. She has just been to their house, but a neighbour told her that they had just left for the airport with plans to go abroad. She asks you to help her by detaining the family as they enter the airport for their flight, so that they can be tested for TB.

1. Do you know your legal obligations in this case?
2. What are your moral obligations in this case? Explain any actual or expected differences between the legal and moral obligations.
3. What ought you to do?
4. Is your answer the same for both adults and children?
5. Would your answer be any different if you were asked to detain someone who had been recently diagnosed with XDR-TB and was planning to fly?

CASE 6: DEVELOPING QUARANTINE GUIDELINES FOR A BUSY PORT

You work in a busy port that is a major centre for both international passenger traffic and freight. There is general concern about how your unit ought to respond to situations where an individual is ill upon arrival, especially when there is a strong suspicion (but no certainty) that the unidentified disease is potentially deadly and highly contagious. You have been asked to help develop a new set of guidelines to help staff respond to the reception of such individuals. Questions to be considered and discussed include the following:

- What ethical issues are relevant to removing an individual from a ship? Should they be first or last off the ship? What can be done (if anything) to protect their privacy?
- What information should be given to the passengers on board? Is this the same information that should be given to the crew? What are the factors (e.g. evidence, risk of exposure, etc.) to take into account in reaching your decision?
- Is it ethical to detain passengers and crew for screening or testing or just because you are unsure of the diagnosis for the ill passenger and are therefore unclear about the possible risk of exposure?
- Should policy prioritize taking precautions (e.g. the containment of possible harm) or individual liberty? What factors may influence your answer?
- If the number of case officers available for investigation is limited, how should priorities about the use of staff time be set? Is it acceptable if staff members are required to work beyond their contracted hours to ensure that individuals are not detained on the boat longer than a few hours?
- What details of such a case can be disclosed to the media? Are there any pieces of information that should not be disclosed? If so, which, and why? What details (if any) should be given to family members who are concerned about those detained on the ship?
- How much information should be given to the people who may have been exposed about the identity of the ill passenger if everyone is screened for contact with him/her? Screening may only be useful if the members of the relevant group know the identity of the person.
- If during screening it becomes apparent that one of the passengers who disembarked at the last port was in all likelihood showing signs of illness, what should you do? Does thinking about such a case make any difference to the answers given above?

CASE 7: A TB OUTBREAK AMONG THE URBAN HOMELESS

There is an on-going tuberculosis (TB) outbreak in the homeless population of a large city in Canada. The city public health unit is focused on identifying those at risk using an outbreak management questionnaire. Those who have come into contact with a TB case, or anyone who thinks they may be at risk, will be offered further investigative tests. Treatment will be given to those affected. However, there is an opportunity to collect additional data by adding a few questions to the questionnaire. Such data would be useful to understanding more about the lifestyle, behaviours and needs of this particular population. They are certainly at

increased risk of this communicable disease, and this information may help prevent future transmission.

It is argued by one of the team that it is not appropriate to take this proposed research to a research ethics board (REB) at this time for the following reasons: the research is low risk; the participants can just refuse to answer the additional questions if they wish; and the preparation of a proposal and related materials to meet the requirements of the REB will take staff time away from actually managing the outbreak. In addition, it is argued that since this group is homeless, it will be almost impossible to find these same individuals in the future once REB approval is received. As a result, a failure to collect the data on this occasion may mean that the research could never be done.

- What are the ethical issues raised by this scenario? Which of these different points or arguments do you think are the most convincing?
- One participant in the group suggests that the data should be collected now and REB approval sought at a later stage. What do you think of this option?
- Another suggestion is that incentives (e.g. cash) could be offered to those questioned during the outbreak to encourage them to keep in touch with the team until REB approval can be sought. Payment would then be made after the research was complete. What ethical issues are relevant here?
- What ought to be done in this case? Give reasons for your answer.

CASE 8: WEST NILE VIRUS (WNV)

West Nile virus (WNV) has emerged as a growing problem in Canada over the last few years since a progressive movement of the disease is advancing through mosquito populations in North America. It is held to be important to maintain long-term surveillance through a number of means, including the sampling of stagnant water for larvae, the trapping and testing of mosquitoes, the testing of dead birds, and thorough investigation of the still relatively small number of human cases. It is important to inform the public about the risks of harm to their health, the status of WNV in their community, and any means to reduce or remove potential sources of transmission, as well as how to minimize exposure.

The WNV surveillance program collects data based on the geographical location of cases as well as other factors. This is a vital means of monitoring the ebb and flow of the disease due to environmental and meteorological conditions. However, data generated by this program raises various potential ethical problems. For example, data collected on positive mosquito traps and positive avian and human cases are carefully mapped. This map is updated weekly and is freely accessible on the Internet. Of course, no reference is made in human cases to anyone's name, address or personal health information, but the site of infection is recorded on the e-map as the nearest major intersection in the urban centre.

- What are the ethical issues raised by this case?
- Do you think the different obligations are correctly balanced in this case?

- What potential problems might emerge through media interest in single cases or clusters of WNV (e.g. around a school or place of worship)? What is the ethical way to resolve them?
- Will your answers to any of these questions change if there is no risk of person-to-person transmission to the public (e.g. if cases of tetanus were mapped instead of WNV). What ought to be done in this case? Give reasons for your answer.

CASE 9: THE GREYHOUND PASSENGER

A Canadian was diagnosed with infectious TB while living (illegally) in the United States. After only 10 days of treatment she disappeared. Upon investigation there were reliable reports that she had left the country to visit family, so she was placed on the CDC border watch list, in the hope that if/when she returned to the United States she would be "found" and brought back into treatment. About a month later, she was apprehended on a Greyhound bus at the Windsor-Detroit border crossing when U.S. border officials checked passengers' documents. She was transferred to Canadian custody, hospitalized in Windsor, and found to be still infectious with TB. She refused to give any information to Canadian public health officials about her travels, where she had stayed in the four weeks since leaving her U.S. home, or with whom she had been in contact. The only verifiable information was that she had boarded the Greyhound bus that afternoon in Toronto, bound for Detroit.

Greyhound does not collect any passenger or seating information, so there was no way to identify the other passengers on the bus, other than the 15 who did cross the border and could be identified from U.S. border records. There were 27 other passengers who got off in Windsor before the border crossing; most had travelled from Toronto, but 12 of them had boarded in London (i.e. a one-hour trip versus the four-hour trip from Toronto to Windsor).

The patient was held to be moderately, not highly, infectious. There is no evidence about transmission rates for TB on buses, only flights longer than eight hours are followed-up upon, and many health units would not consider four hours of exposure to be significant. Two of this patient's three children were tuberculin skin test positive, but the follow-up with her contacts in the United States showed no evidence of transmission outside of the household.

- What ethical issues are raised by this case?
- What should the public health department do in relation to the Canadian contacts of this patient?
- Are there any broader societal issues raised by this case? How if at all are they relevant to the ethical issues?
- How should they be resolved?

CASE 10: 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 this 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, which provides 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 their use of supplies to balance the budget. Moreover, overall reductions in the healthcare 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 for infection of 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?

This case highlights the duty to provide care, stewardship, solidarity, reciprocity, trust/fidelity and accountability. Other values that could be considered include: evidence, equality/equity, social responsibility, liberty, and freedom.

CASE 11: 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 he 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, he refuses to be vaccinated. What is to be done with Dr. M?

What values are at stake?

Liberty, freedom, respect for autonomy, efficiency/effectiveness (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

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?

- 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 the health authority or province). If such policies do not exist, are steps being taken to draft them? 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 healthcare 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 (the priority for antivirals is to treat infected individuals).

CONCLUDING REMARKS

It would contrary to the spirit and purpose of this collection, and to this early exploratory phase in the development of the NCCHPP's work to open up public health ethics in ways relevant to the work of front line practitioners and policy-makers, to attempt to draw any detailed substantive lessons or prescriptive guidance from these cases. The intent behind the publication of this document was never to provide formal step-by-step procedures that could be followed in sequence to address and resolve complex and challenging public health issues in any comprehensive manner (although such guidance is beginning to emerge in the literature). Nor was it to recommend any particular set of values, decision guide, or framework of principles (although a variety of such tools have been proposed and continue to evolve in light of ongoing scholarship and multidisciplinary debate and evaluations). Instead, this series of cases has been made available as a starting point for a longer-term dialogue about integrating ethics into routine and emergency public health practice and policy. It is also an attempt to encourage and support exchange and debate among academics and practitioners in order to enrich the process of developing and using ethical concepts and reasoning when difficult choices and trade-offs are required to protect the public from threats and prevent the spread of disease and avoidable death.

Accordingly, we welcome your comments on this document, invite your feedback on the usefulness and relevance of its contents, and encourage you to send us questions or make suggestions based on your experiences if it can help attain the goal of enhancing practical and policy-related ethical decision-making in the field of public health.

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