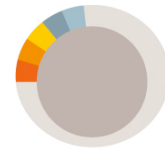


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**PANDÉMIES, ÉTHIQUE, SOCIÉTÉ**



### ***Pandemic Influenza – A Social Science Perspective***

**Robert Dingwall, Director, Institute for Science and Society, UK**

The issue of the proportionality in discussing issues is of great interest. In this field, a paper written in the 1980's by Philip Strong, about the early phases of the HIV-AIDS epidemic should be mentioned. My work largely consists in reinventing the tradition of sociological work on mass behaviour. There has been much work in that field at the beginning of the twentieth century, especially in France with people like Gustave le Bon or Gabriel Tarde, who had influence in Germany and on the work of Robert Park in the United States. The subject pretty much died out by the 1950s.

Philip Strong thought it was worth continuing and he drew a comparison between the initial response to the HIV-AIDS epidemic and the emergence of the Black Pest in the fourteenth century. Among other things, he pointed out that new diseases are only scary for a limited period of time. At the beginning, people tend to think it means the ends of civilisation. They adopt all sorts of strange behaviours to propitiate the gods, or to find some solution to this social challenge. When they realise that not everybody is dying (which happens when the event has occurred two or three times), they think about plagues as an institutional nuisance. The government establishes procedures to deal with it and everyday life goes on quite as usual.

In the first phase, there is a lot of anxiety, but it tends to vanish. It is important in getting public and government attention. It does suggest what may be plausible scenarios, but it does not tell us much about what the potential epidemic will really be. The reference everyone has in mind is the 1918 flu pandemic, but virologists believe it may be the limit of virulence: if a virus kills too many people too quickly, it cannot transmit and burns out. In evolutionary terms, viruses are selected against if they kill too many people too quickly. There is ground to believe that 1918 is very near the selective cut-off.

**The past provides many references to imagine how severe a pandemic might be**

According to some historians, the so-called 'sweating sickness', in the 1520s, might be a previous instance of such an epidemic. Although there is much debate on the diagnosis, the symptoms as described at the time, as well as the lethality of the disease are consistent with 1918-type influenza.

The fact that historians were not able to come up with any other example between the 1520s and 1918, which shows that 1918 style influenza is quite an uncommon event in the history of pandemics. The flu epidemics of 1957 and 1968 are of a much more relevant type to think about in order to plan for the future. Such a pattern of epidemics would still be a challenge for the healthcare system, because the margins in terms of bed capacity have been reduced since that time in search for efficiency.

In such events, the mortality affects mainly the older people, which would probably have died a few years later, and the younger children. It would mean acceleration in mortality, but such a phenomenon would not bring waves of mortality similar to those reported in 1918.

Anyway, one must keep both messages in view. "After all, it might be 1918 all over again". A planner must take that possibility into account too. It is much more powerful in terms of release of resources, but it also means rethinking our entire biomedical ethics system. Maybe there is a risk of getting out of proportions. Maybe what will really be needed is a business as usual with a bit more imagination and practicality.

### **What is the nature of the challenge?**

Across Europe, most governments are still seeing this as a public health emergency, with the Ministry of Health in charge. Even in the 1968 pandemic flu was a civil emergency. That is the reason why in Britain, planning has been taken away from the Department of Health and given to the Civil Contingencies Unit in the prime minister's office. That department reports directly to the Prime minister, with power to coordinate cross-government, and to work with the principal actors in its sector. The ethical biology committee, initially created by the Department of Health is now a cross-government committee. Other departments are invited to test their plans with the principles articulated there. The integration required between the departments is in itself quite a challenge.

The question of the coordination between the public sector, the private sector and the NGOs sector cannot be left aside. Although it seems the private sector has been properly engaged, the NGO sector has been a bit left behind.

Yet there is some frustration left in the private sector, with the government not really articulating what comes from it. It would be interesting to bring together the people involved in biomedical ethics and in social responsibility. We tend to separate the sectors, but they actually have quite a lot in common. It will probably be easier to build bridges between corporations and healthcare actors than what is usually thought.

### **Social contract and doctor/patient relationship**

Contract between professionals and the society has been much discussed. The sociologist has a lot to say about this issue. In return for status, privilege, high pay, *etc.*, health professionals are expected to behave differently from the rest of the population. The question is that of the moral obligation of a

professional in a time of crisis. They get advantages from the society, but they have obligations in return.

Obviously, healthcare workers are sometimes tempted to discuss the terms of the contract. For instance, the labour relations in a hospital might affect the reaction of the staff in crisis times. In some hospitals, nurses are hired on “zero hours” contracts, where they work only if they are needed. They usually have several part-time jobs. It is highly dubious that they will be willing to risk their lives without thinking twice at that. We need to assess the consequences marketisation in the healthcare system. It undoubtedly affects the contract between the society and the professionals.

Ethics cannot be separated from social contexts. Would doctors become agents of the state? A sociologist would probably rather talk in terms of agents of society. They are agents of the society in managing social deviance. Sickness, as Parsons points out, is a kind of social deviance. It is managed in a space of dependency, by the doctors. It is the same role as that of traditional healers, although doctors will always deny it. The claim doctors make of their autonomy is quite important to legitimate its function towards the patient. It is also a way to give some sense to what the doctors are doing.

### **Security is everywhere**

Professor Brigitte Nerlich has written a lot about the war metaphor in relation with the foot and mouth disease that plagued the UK 2001. Actually, it has been used for years in the medical vocabulary. It came into public health with a military background. It is a complex history, but we should understand why that metaphor is so much in use at present. It goes with the way it mobilises resources.

It is amazing to see how much social science research has been done in the US since 2001 in the field of security. The integrity of the American family has been presented as a problem of home land security. It is something about paternalism. There is no fundamental difference between what the doctor-patient interaction was in the seventies and what it is today. It relates to the way that relation is constructed by the parties. A lot of patients are expecting doctors to tell them what to do. This is another legitimisation of the social role of doctors in the space of dependency.

We have already talked about some pieces of legislations like prioritisation of particular groups, which legislators will not take even if the public would probably be asking for them. It is the duty of the legislator not to do certain things, even when the public would be ready to endorse them.

Another main issue deals with children’s fate: there are practically no good therapies for children. Therapies are developed in based on demand way. There is very often not enough demand for children. It is impossible to put a child in an adult ICU bed. Tools and devices can not be easily switched form one kind of bed to another one.

The last question that can be raised is: how to deal with cultural minorities (for instance on the question of dead disposal)? The issue has been debated with religious leaders. Most Britons prefer to be cremated. The question is whether those for whom cremation is central to their religious belief would get priority access to the crematoria over those for whom it is a simple convenience.