The human, social and political consequences of a possible pandemic influenza deserve better treatment than a few formal resolutions or the organization of debates among specialists. We must create the conditions to allow the involvement of all levels of society, to foster creativity and encourage participation. While all sorts of plans are being drafted to reassure and organize, using coherent intervention methods and risk-mitigating strategies, ethical approaches have so far been quite sparse. They are, at best, limited to a few humanitarian generalities or vague considerations.

The values, resources and references of democracy will be directly challenged by a disaster that may shake its foundations. These are the stakes: how can we, as democrats, fight against a pandemic, which like other threats, can affect our principles? PANDEMICS® will contribute to the dissemination and confrontation of opinions and proposals developed in France and throughout the world, in particular in the fields of human and social sciences.
Observation & Reflection Platform on Pandemic Influenza, Ethics and Society

In early 2006, the Paris-Sud 11 University Ethics Research Department and the Espace éthique of the Assistance Publique-Hôpitaux de Paris decided to adopt an interdisciplinary approach to the ethical and social issues of pandemic influenza and set up an expert network. Over the coming months, this network will be developed, aiming notably to work at the international level with structures or authorities involved in the same field of action. Its missions are to monitor developments, identify the questions arising with respect to the influenza pandemic, analyse proposals put forward by public authorities, contribute to research and publication of information, awareness-raising, public debate and choices.

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Observation and Reflection Platform on Pandemic Influenza, Ethics and Society

ESPACE ÉTHIQUE/AP-HP

Ethics & Pandemic Influenza

September 2007

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Research Department

Emmanuel Hirsch

Coordination

October 2006

Members of the Scientific Council

Awareness-raising, public debate and choices.

Its missions are to monitor developments, identify the questions arising with respect to the influenza pandemic, analyse proposals put forward by public authorities, contribute to research and publication of information, awareness-raising, public debate and choices.

11:30 Break

11:45 Discussion

Session Chair: Aridre-Dottin

Professor of public health, head of the pandemic care unit, assistant professor of virology and medicine, President of the national conference of the American Society of Tropical Medicine and Hygiene, Jean-Yves Le Gall

Professor of anthropology, Vice-Chancellor of Rouen University

Sandra Prost

Didier Tourancheau

Friday 13 October 2006

Paris-Sud 11 University

Observation and Reflection Platform on Pandemic Influenza, Ethics and Society

Session Chair: Daniel Tarantola

Professor of preventive medicine and health policy, Director of the Department of Ethics, Human Rights and Health Law, École polytechnique, Paris 1 University

Discussion

11:00 Lunch

Free entry (when participants book early)

www.espace-ethique.org/fr/gpige.php

Ethics in the Pandemic Influenza Era

Ethics & Pandemic Influenza

I - Ethical stakes, democratic challenges

10:15-10:45

Session chair: Didier Tourancheau

Discussion

10:45-11:00

Session Chair: Emmanuel Hirsch

Professor of public health, head of the pandemic care unit, assistant professor of virology and medicine, President of the national conference of the American Society of Tropical Medicine and Hygiene, Jean-Yves Le Gall

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Taking a stand

Here we are, involved in an active and determined solidarity from which a feeling of a shared responsibility towards one another emerges.

Jonathan M. Mann

Theoretical planning and studying lessons learned from other significant events are ways to prepare for the eventuality of pandemic influenza. However, speculation by experts and planned measures cannot alone create the conditions required to mobilize and reinforce social cohesion around shared values. While it is essential to define a framework for action, this framework can only be devised and developed through a dialogue bringing together all of the required competencies and generating the necessary controversies. The legitimacy of sensitive options and decisions, very complex in an uncertain and constraining environment, will be linked to the quality and relevance of this debate. A pedagogy of shared responsibility thus appears essential. The challenge here is to create the conditions for multipartite discussions, to distinguish and thus express a conscience, a vigilance, and motivated and effective commitments within society.

The very idea of a pandemic seriously challenges our liberties and democracy itself. Only if we are aware of this challenge can we conceive our responses and take a stand. Pandemics, the Observation & Reflection Platform on Pandemic Influenza, Ethics and Society at Paris-Sud 11 University, and the various conferences organized in the coming months all reflect this position: our opinions are inspired by this need and are expressed from this perspective. Beyond the possibility of a pandemic, the need to act as a society and to face the challenges of our times encourages us to regain confidence in our ability to imagine and invent the future together.

M. G. – E. H.

To Jonathan M. Mann, director of the WHO International AIDS Program (1986-1990), director of the François-Xavier Bagnoud Centre for health and human rights, dean of the Public Health Faculty at Allegheny University until his death with his wife Mary Lou Clements-Mann in the crash of a Swissair flight on September 3, 1998.
A COMMITTED UNIVERSITY

Anita Bersellini
President of Paris-Sud 11 University

Our university has chosen to confirm its vocation within the community by promoting an ambitious concept of citizenship. Research, knowledge acquisition and dissemination are strong democratic values. This is how a university becomes involved and assumes its responsibilities in society.

In today's increasingly complex, uncertain, and preoccupying world, the notions of rigor and concern for others impose themselves on us all. Knowledge should serve the public good, contribute to more justice, and especially encourage our capacity to adapt to the world's challenges.

Inventing, exchanging and communicating knowledge requires an unflagging awareness of our duties.

Our Ethical Research Department has decided to devote a portion of our activities to the anticipation of a possible influenza pandemic, in partnership with the Paris Hospitals' Ethics Committee. This initiative is a first in a university framework in France, and is all the more important since we believe that the human and social impacts of an influenza pandemic have not received the attention we could expect in the systems that have been officially presented.

It was necessary to set up a network of skills. Within a few months the Observation & Reflection Platform on Pandemic Influenza, Ethics and Society has become a melting pot for cross-disciplinary reflection, especially in the field of human and social sciences.

This concertation and debate has led us to launch other initiatives. The Platform, associated with its partners, will be proposing four thematic university conferences in the coming months. The first one held on October 13 is entitled "Ethical issues: challenges for democracy".

This reflection also required a medium to encourage exchange and the dissemination of research. By publishing Pandémiques in French and Pandemics in English, the Paris-Sud 11 Ethical Research Department demonstrates that not only is questioning possible, it is an obligation for us all when faced with the challenges of a pandemic.

Within a few months our University has thus created the conditions for an ethical and societal approach to accompany policymaking choices.
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THINKING ABOUT AN EXTREME SITUATION

Our society is not morally prepared for a pandemic. The elaboration of detailed measures in the framework of duly planned strategies has uncontestable virtues. Through forward planning, we can mitigate the consequences of a global social crisis: we are reminded every day of its due date, though uncertain. Organization, as rigorous as it may be, can turn out to be vulnerable when phenomena and factors outside of our control thwart decreed rules and reasoning. Despite an ideal or an ideology of precaution, scientific expertise has its limits, particularly when faced with a new and inevitable situation. The initial, required phase of administrative planning must be followed by real mobilization, for which we could even state that we are now ready. We must bring ethics into play and unite around identified and shared values. Assuming obligations in a time of danger requires going beyond the circle of specialists. Democratic principles may not survive the ordeal of a pandemic.

While plans are being drawn up across the world to deal with the spreading of the H5N1 virus, little attention is given to the ethical aspects of the planned measures. Terms or notions such as ethics, moral standards, dignity, human rights or deontology are not even explicitly mentioned in the French government’s influenza pandemic preparedness plan[2] It’s as though the disaster scenario already takes into account the human and moral cost of a pandemic influenza and the ineluctable character of its consequences.

Government plans currently proposed in many countries give the false assurance that the phenomena resulting from the pandemic will be controlled.

We thus refuse to imagine a situation of partial or complete disorganization, with all sorts of uncontrolled rumors and data circulating in a psychological context encouraging the irrational. How can we preserve and reinforce essential confidence when a disaster arouses terror and despondency? The morbidity and mortality forecasts reveal the extent of the possible disruptions, with immediate effects on the continuity of public life, social practices, relations within families, attitudes and behaviours, and rites at least for the deceased. Equity, the respect for a person’s dignity and rights, the preservation of the most fragile will quickly lose all substance while acts of violence and incivility will accentuate insecurity and fear.

How can we outsmart the worst strategies and avoid that a state of exception justify arbitrariness? In a social context where individualism, suspicion and defiance prevail, nothing allows us to be assured of a unanimously

ENGAGING ETHICS IN VIEW OF A PANDEMIC INFLUENZA

“Any person who plays a role, if he is does not awaken ethics and a sense of responsibility, is a liar.”

Claude Bruaire[1].
shared concern for the common good. How can we envisage a pedagogy of responsibility?

The values to be preserved must be ranked: loyalty, integrity, equity and transparency are vital in the determination and the control of choices. The constitution of active solidarities will improve our practical response capabilities but also our resistance to excess. It is the role of ethics organizations to contribute, in their fields of competence, to the necessary reflections. It is an emergency: they are committing their responsibilities to the service of the country.

**Citizen empowerment**

In the foreword of the Avian Flu Information Mission’s report to the French parliament, its chairman, Jean-Marie Le Guen, made public his letter addressed to Jacques Chirac dated June 12, 2006. He “observe[d] that our health care system and, more generally, French society are not prepared to face a possible pandemic”. His statement was completed in the newspaper Libération, on June 14: “If the pandemic arrives, it will cause the dismantling of social life”. In the name of urgency and efficiency, have we given up considering it useful to consult with and mobilize people beyond the specialists’ inner sanctum? Do the recommended measures take into account the complexity of social realities and are they able to produce adapted, coherent, just and acceptable answers? According to what conditions and with what type of support will professionals carry out their missions? How can we assess a society’s level of preparedness when faced with a global yet imprecise risk, which only technical anticipation and prevention measures appear to be able to mitigate? Does political sense, particularly in the sensitive area of public health, now not consist in focusing on the details and the exhaustiveness of organizational measures, as all other considerations appear risky and debatable?

Precaution, a doctrine of action, has become a management principle that imposes its rules and takes the place of an ideological debate. We rarely take umbrage, in particular when it is a matter of “protecting, preparing, detecting, improving, limiting, ensuring and maintaining”, terminology used several times in the introduction to the government’s plan presented January 6, 2006.

The drafting of the government’s national pandemic influenza preparedness plan reveals that the expertise of a few was preferred to public deliberation and to grassroots consultation calling on other types of intelligence and sensitivities, and yet the latter is the way to bring people together and reinforce shared values. Conventions concerning AIDS, health, and cancer have eloquently proven the social value and relevance of layman’s expertise. We must, however, be very pleased that researchers from the London School of Hygiene & Tropical Medicine[3] considered the French government’s plan to be the reference in Europe last April. The report nevertheless underlines the “difference between evaluating country plans and determining countries’ preparedness”.

My observations on the method do not detract from the fact that our government’s plan represents a strong and resolute commitment that many countries envy.
We can consider this plan as the expression of a formal but necessary framework that we should now try to concretely connect to the human and social stakes of a pandemic threat in order to make it accessible and operational. In his letter to the French president, Jean-Marie Le Guen “observe[d] a political hesitation to become actively involved in citizen empowerment”. This citizen empowerment cannot be just a slogan or a hollow concept. AIDS activists have taught us its usefulness through commitment, and sometimes resistance, to serve the common good and the country, and how a society can reveal and surpass itself by assuming its challenges and true ambitions with dignity.

A spirit of initiative and the culture of courage and daring are preferable to the ideologies of misled precaution and individual confinement put forward by some. We must now “breathe life into this plan”, as was well said by Xavier Bertrand during his New Year’s greetings to the press on January 13, 2006. We must be creative, generous, realistic and supportive in order to elaborate and assume together the terms of an ethical and political commitment that is within our reach. In this way, we can usefully contribute to the actions proposed by the government. Together, we must think of and assert the democratic values that must drive our decisions during a pandemic. It is in this way that we’ll be able to create this “bond of confidence” in our society indispensable to the voluntary exercise of our mutual obligations.

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The community view of the infected patient: victim, threat, accomplice, culprit?

At the heart of medical practice, there is a latent conflict between the duty to help the sick in the best way possible and the duty to help the community. Infectious diseases with inter-human contagion endanger not only the health of the patients affected, but also the health of the people who surround and are in contact with the patients, including health care professionals.

For this reason, infectious diseases have always generated an extremely ambiguous vision of the patients and people exposed, simultaneously considered victims, threats, accomplices and even disease-propagating culprits. This has often caused stigmatization, exclusion, or even de-humanization, that are reinforced by the fact that the exclusion of patients and exposed people often represents in itself an effective preventive measure for the community.

How can we relieve suffering and provide care without placing ourselves and others in danger? How can we apply preventive measures without stigmatizing or excluding? How can we isolate without abandoning and without exposing those we isolate to the risk we wish to protect others from? How, when trying to preserve activities essential to the survival of a community, can we avoid separating the population into “useful” people and the others, and avoid abandoning those who are even more vulnerable once they are considered “useless”? How, in exceptional, emergency or panic situations can we remain faithful to the great principles of “liberty, fraternity, equality”?

Considering oneself as a victim or a threat: the shifting boundary between “ourselves” and “others”

When engaging necessary reflection on the way we behave with “others”, we must take into account the ambiguity of this notion in the event of an epidemic. Indeed, when we envisage ourselves in such a future, we can either imagine ourselves as exposed to the danger of infected “others”, or on the contrary as already infected ourselves and awaiting assistance from non-infected “others”. Being able to simultaneously envisage these two opposing (yet complementary) situations with the same outlook is probably one of the major challenges of ethical reflection – a reflection that consists, in the words of Paul Ricoeur, of “thinking of oneself as another”.

A pandemic influenza preparedness plan
Promoting the values of mutual aid, responsibility and solidarity

Jean Claude Ameisen
Professor of immunology, Paris 7 University, Chairman of the Ethics Committee at INSERM, member of the French National Advisory Ethics Committee, member of the Scientific Committee of the Observation Platform on Pandemic Influenza, Ethics and Society at Paris-Sud 11 University
There is another boundary between “ourselves” and “others”: infectious diseases are not only sources of vulnerability and abandonment – they are also diseases caused by vulnerability and abandonment

Whether on a global or national scale, epidemics are often diseases that affect the most vulnerable. Tuberculosis is a good example. The development of this disease is closely linked to socioeconomic and cultural conditions and the access to prevention and health care systems. The incidence of the disease is much higher among poor populations in the poorest countries of the southern hemisphere and among the poor people in our country, as illustrated by its frequent occurrence here among the homeless, prisoners and immigrants. Tuberculosis illustrates how difficult it is to design effective policies to prevent and treat an infectious disease that affects the most underprivileged members of the population.

Pandemics, natural disasters, vulnerability and abandonment: tuberculosis, AIDS, heat waves, hurricane Katrina...

Tuberculosis is not the only example of such a situation. The tragedy of the heat wave in France showed that the population was able to take the appropriate preventive emergency measures for the most physiologically vulnerable population group (newborns and babies), while forgetting and even abandoning the people who combine severe physiological vulnerability with a high degree of social vulnerability linked to isolation and non-integration (the elderly). The heat wave tragedy also revealed the importance of family and local solidarity in the implementation of preventive measures, and the ease with which abandonment can occur, reinforced by the implicit notion that institutions and the State will take care of the problem. For this reason, one of the objectives of a plan to combat a “natural” threat should probably place a strong focus on raising the population’s awareness of the interest of developing local solidarity networks among themselves.

Hurricane Katrina, which recently devastated New Orleans, is another example of the particular vulnerability of people who are the most socially underprivileged and/or have the most fragile health conditions. These very vulnerable people represented most of the victims. The absence of any significant intervention by the national government encouraged the disintegration of social cohesion, leading to looting and mugging. In other words, while the tragedy of the French heat wave revealed the importance of creating local solidarity networks, the tragedy of New Orleans illustrated the importance of a national government’s commitment to maintain social cohesion and provide aid to the most destitute. These two tragedies also highlighted by default the importance of real-time communication of useful information and recommendations to the population at large and to professionals who can then intervene rapidly and effectively.

To return to the subject of infectious diseases, AIDS is essentially propagated today among the poorest populations in the southern hemisphere. In wealthy countries such as the USA, most of the recently infected patients are from socially underprivileged minorities. The poorer, more vulnerable and socially excluded the populations, the less good prevention and treatment methods are accessible. Yet the AIDS pandemic has also caused a genuine revolution in terms of solidarity which has led to profound behavioral changes. The current role of patients’ associations, considered full-fledged partners in prevention policy implementation, therapeutic choices and clinical research, has been shaped by AIDS. The same holds true for the fight against discrimination, the respect for confidentiality and informed consent, and appeals to individual responsibility in terms of prevention. On the international level, the importance of human rights and especially women’s rights in the development of an effective prevention policy has been recognized, along with the need for a global response, based on sharing and allowing poor countries to access the most recent, costly medicines protected by patents, in the form of generic medicine.

The above-mentioned tragedies have been the subject of many analyses and initiatives taking into account the notions of vulnerability, discrimination and exclusion. Rather than focusing on the obvious differences between these tragedies and a possible influenza pandemic, it would be useful to ask ourselves to what extent the lessons learned can be transposed to the context of a pandemic influenza preparedness plan.
DEALING WITH EXISTING SITUATIONS OF VULNERABILITY, WHETHER A PANDEMIC OCCURS OR NOT

Setting up a national pandemic influenza preparedness plan is vital. Yet perhaps one of its major benefits is to help reflection go beyond the plan’s initial scope of application. The tragedies mentioned above all highlight the risk of forgetting or abandoning the most vulnerable in the event of a collective threat. Faced with the threat of a pandemic that would combine most of the characteristics of those tragedies, should we not start with the principle that any pre-existing situation of vulnerability, and especially any situation where social ties are fragile or already broken, will expose people to the risk of abandonment, and that we must try to identify and analyze these situations today in order to try to solve them in the most effective way possible?

This type of approach could allow society to undertake an in-depth analysis of the notions of solidarity and responsibility, which would go beyond the simple perspective of preparation, indispensable but necessarily limited, for the possible occurrence of an influenza pandemic. Such an approach would not only allow us to better approach the prevention and handling of other disasters that are unpredictable today, but above all to identify and try to solve the existing daily situations of vulnerability that persist and are neglected or considered inevitable.

It would also allow us to expect and assess beneficial effects from the plan’s implementation, even if (as we all hope) a pandemic does not occur.

In a more general fashion, this type of prevention approach, whose objectives go beyond the disaster that we wish to avoid, could represent a model that would give the “precautionary principle” the additional dynamic and positive dimension that it lacks today.

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[1] Reflection carried out in the framework of a working group of the French National Advisory Ethics Committee composed of Sadek Beloucif, Chantal Deschamps and Didier Sicard.
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Expecting the worst

How can we prevent the disturbances caused by a flu pandemic such as the one the avian flu threatens us with from making Machiavelli’s wisdom urgent? One thing is certain: the temptation to confuse morality with the administration of fine sentiments would be useless. The very idea that there is an absolute Good that can orient behavior and dictate categorical imperatives would no longer have any power. If a “morality of misfortune” exists, comparable to the one that Georges Bataille tried to identify in Camus’ The Plague, it cannot be Kantian. It cannot be utilitarian either, since as the avian flu becomes everyone’s business, thereby smothering initiatives in complex interdependency, the consequences of a particular act appear unlikely to serve as criteria for a moral assessment: consequentialism is favorable to individualistic rationales, when they can satisfy the search for what is the fairest for each person rather than the search for the common good. It reaches its limits in a context where causes and effects are intricately intermingled almost to the point of confusion, where the feeling of being powerless discourages the calculation of what is best.

Each individual acting to maximize his own chances of survival would rapidly discover that he aggravates the collective disorder, by making obvious the lack of coordination of the ends. A pandemic could very well defy the analytic rationality required for moral judgment based on assessing the beneficial consequences of an action. I do not mean that anomie would be our destiny and that regulations could no longer preserve social ties. Nor do I mean that the application of best practices would become useless. It is simply necessary to suggest, in order to anticipate the worst, that we could find ourselves in an exceptional situation such that yesterday’s confidence in safety would no longer structure behavior, and such that no deduction would suffice to envisage a “devoir-être” (way of being).

Combative humanism

With this catastrophic scenario as our backdrop, why not take lessons from Machiavelli, whose philosophy, too rapidly perceived as nefarious, focused on the dependence of the restoration of peace - and thus of morality - on the strength of politicians with no morals. A pandemic, like the wars that Machiavelli wished to end using all possible means, would cause an upheaval in moral values and the eradication of obvious behaviors which, to be halted, would require an exceptional government ready to impose a reversal of values. That which is condemned in peacetime (vice in general) would actually appear to be a virtue.

It would be wise to anticipate the excesses that the occurrence of a pandemic should unfortunately lead us to expect.

Jean-Michel Besnier
Professor of philosophy at Paris 4 Sorbonne University, member of the Scientific Committee of the Observation & Reflection Platform on Pandemic Influenza, Ethics and Society at Paris-Sud 11 University
The ethical question will have to be returned to its original expression: how can one guarantee the conditions for individual and collective well-being and at the same time stabilize the chaos that accompanies all human reality? When envisaging an avian flu pandemic, I thus turn towards Machiavelli’s humanism, and his esthetics of the individual: a humanism of combat, such as Sartre or Merleau-Ponty would have evoked in the context of the disaster of the wartime years; an esthetics of virtù as opposed to the quirks of fortuna.

Let us draw energy without despair from the argument that since all humans are fundamentally bad, they are also free to resist determinisms as much as the absurd. Let us make Machiavelli’s wisdom the lever upon which we must lean in order to avoid the terrible eventuality of complete disorganization: “Men should indeed never give up, for, since they do not know [fortune’s] end and it proceeds by oblique and unknown ways, they have always to hope, not to give up, in whatever fortune and in whatever travail they may find themselves.” (Machiavelli, Discourse upon the first Ten Books of Titus-Livy, II, 29).

**PANDEMIC INFLUENZA AND ETHICAL REFLECTION**

**What are the requirements for a management at the level of the stakes?**

“If reality is inconceivable then we must invent inconceivable concepts.”

— Hegel

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**Strategy**

Major upheavals for civilization – such as a 1918-type pandemic influenza in our now globally interdependent environments, extremely sensitive to exceptional disturbances and thus in many respects not very resilient – call for reflection and preparation equal to the challenges. Our systems would lose their markers very quickly and on many fronts: a brutal increase in the collective death toll, the failure of essential systems such as hospitals and supermarkets (one day’s worth of stock), and the multiplication of major malfunctions in the operation of our essential infrastructures, without which our socio-technical systems cannot function. The loss of control in a world considered to be “under control” would cause a drastic plummeting in confidence levels, opening the door to all sorts of unpredictable reactions, starting with the highest spheres of decision-making, which have never been prepared for such confrontations.
For the time being, the primary focus is on plans: the categorization of situations, the clarification of the rules to follow in standard situations, i.e. on the tactical level: masks, medication, behavioral recommendations; and on the now unavoidable level of communication: the twofold objective of informing and preventing panic. Informing most often consists in explaining the virus in question, the government plans, and the measures taken to allow organizations to get over the hurdle of several difficult weeks.

We also see some attempts to examine ethics issues, but these remain quite limited. Basically, we are living in societies based on the premise of a quasi-perfect control of malfunctions thanks to technical, tactical, organizational and procedural systems. For any important issue, the protection pact between leaders and citizens functions to the full: the former reassure the latter that they are protecting them and the latter demand to hear this – no one is really adding any credence to the process, which will last as long as the “strange war” does. Raising questions for which we have no answers or opening up a script that is not fully written is considered somewhat of a blasphemy in our post-industrial societies. Of course, there are always enough sufficiently intrepid people to take certain liberties with this collective way of operating and to raise some questions on the sidelines – once it is clear that everything is well under control. But these interesting advances, though they can be praised compared to the norm, remain out of touch if we consider the real theatres of operation that we may be called to. Relocating our uncertainties off to the sidelines is not relevant when a storm is striking the center.

The loss of control in a world considered to be “under control” would cause a drastic plummeting in confidence levels, opening the door to all sorts of unpredictable reactions, starting with the highest spheres of decision-making, which have never been prepared for such confrontations.

In fact, raising ethical questions supposes opening a “blank” space in which questions emerge – without paralyzing the person who raises them, or the person receiving them – in the place of pre-formatted answers. In the many conferences organized on pandemic influenza, we searched in vain for a strong ethical position. For the most part, they gave priority to the presentation of scripts written by the authorities in charge. When the threat becomes clearer, the risk would be to compulsively try to find even more protective answers in formal models, postponing even further the moment when we’ll finally have to allow open and shared questioning.

Ethical questions

While putting forward our battery of answers, those exercises that allow us to test our capacity to apply the supplied scripts, we also know that it is important to open up secondary forums of discussion in case our plans, like Joffre’s plan XVII in August 1914, turn out to be less effective than planned.

We would then be considering the most complex problems that would be impacting the public scene in the case of a major shock. A Canadian study examining the SARS case[3] put forward the following lines of questioning that may be interesting to examine in terms of a reflection on pandemic influenza:

- individual freedom
- privacy
- protecting the public from danger
- protecting communities from unjustified stigmatization
- proportionality
- duty to provide health care
- reciprocity
- equity
- transparency
- solidarity

It also raised the following issues for discussion:

- quarantine issues: individual freedom vs. collective protection
- information issues: protection of privacy vs. collective safety
- issues concerning those most exposed: their protection vs. the risks that they may increase
- issues concerning isolated persons outside of the system
- issues linked to solidarity on a global scale

Another front however must be opened that addresses ethics, somehow reversing the chronological entry point.

In the many conferences organized on pandemic influenza, we searched in vain for a strong ethical position. For the most part, they gave priority to the presentation of scripts written by the authorities in charge.
We no longer simply ask ourselves what we could or should do the day the pandemic hits, we consider it essential to raise the question here and now: what are the requirements for preparation, firstly, as concerns managing the issue and, secondly, all of the actors?

We should start with some hard lessons learned from experience:
- Our governance and leadership rationales were not designed for a world marked by severe turbulence, or virtually chaotic navigation. As Sun Tzu would say, the risk is then very high of being defeated in each battle.
- When we are structurally late in a war, the first effect of the first signs of difficulty is dramatic paralysis. This is what explains the countless mistakes that subsequent investigation commissions then list: “a failure of imagination”, “a failure of leadership”, “a failure of initiatives”, etc.
- If we feel that there is a real gap between what we need as of now in terms of forward planning and leadership capacities and our current common references, then even the aim itself of changing this is seriously handicapped. We generally observe: avoidance of the subject, technical-oriented illusions ranging from an obsession with tool-answers for everything to formalizations that are more seductive than relevant, refusal to really open leadership up to essential actors (large networks or NGOs), constantly open or suggested fear of “panic of the population” that can rapidly replace a happy-face communication style with authoritarian reasonings intended more to protect the organizations in place than to deal with the situation.
- We need a real reversal of perspective on democracy during a time of chaos.

A few lines on this topic from the remarkable book by John M. Barry on the 1918 pandemic: “In 1918 the lies of the officials and of the press never allowed the terror to condense into the concrete. The public could trust nothing and so they knew nothing. So a terror seeped into the society that prevented one woman from caring for her sister, that prevented volunteers from bringing food to families too ill to feed themselves and who starved to death because of it, that prevented trained nurses from responding to most urgent calls for their services. The fear, not the disease, threatened to break the society apart. [...] Those in authority must retain the public’s trust. The way to do it is to distort nothing, to put the best face on nothing, to try to manipulate no one. Lincoln said that first, and best. Leadership must make whatever horror exists concrete. Only then will people be able to break it apart”.[4]
(Barry, p. 461).

To counter these fiasco scenarios, the approaches are already partly known: work on the questioning, develop creative intelligence in addition to solely procedural intelligence, open up the networks, place confidence and shared responsibility at the core of the processes, accept to start preparing for inconceivable situations – as opposed to ritual meetings where the good word is delivered, be it scientific or regarding leadership, etc.

The challenge is to understand how to burst this protective “bubble” that ensures a doubly false protection of decision-makers and citizens. On one hand, we must ramp up our shared lucidity, and on the other hand, we don’t know how to talk, lead and share as soon as we leave our “formal gardens” with their very domesticated risks to move to the “unthinkable” fields of ignorance and chaos.[5] Attacking this fundamental question with determination is perhaps our first ethical duty today.

References

[1] These few reflections were largely inspired by our mission to Toronto, undertaken with the support of Pierre Béroux, Head of Risk Control at the Électricité de France Group.
The ethical considerations involved in planning a response to pandemic influenza

Report drafted on behalf of the Avian Flu Information Mission: preventive measures

The previously mentioned report by the Joint Center for Bioethics of the University of Toronto lists the ethical issues at the heart of any national pandemic preparedness plan. The reporter highlights three main issues that are especially relevant when analyzing the French plan.

The first concerns the duties of health professionals. The Toronto report declares that "[for them] the duty to assist the ill is a basic ethical obligation" and recommends that in exchange they benefit from special protection (treatments, life insurance, etc.). It also recommends that professional medical societies expressly and regularly remind their members of their ethical duties.

In France, Pierre Monod, speaking on behalf of the regional societies of general practitioners (URML) confirmed to the parliamentary commission that "there are citizenship duties to be recalled within professional groups, and influenza provides this opportunity - hence the importance of training and follow-up meetings".

The second issue concerns the measures restricting public liberties that may be imposed, such as quarantine measures. The University of Toronto report pleads for the proportionality of such measures, the transparent and openly debated nature of their adoption procedures, and a respect for the privacy of the people concerned.

From this standpoint, we must profoundly examine the balance between the legal regime of the "state of emergency" described in the French law of April 3, 1955 and the stakes of a health crisis. On the other hand, as concerns the prerogatives granted to the Minister of Health by article L. 3110-1 of the French public health code (see above), it should be noted that this code defines a framework for their attribution and exercise conditions as is recommended by the University of Toronto researchers.

Indeed, according to this article L. 3110-1, "a serious health threat requiring emergency measures" is required. As for the measures prescribed, it should be underlined that from a formal standpoint, any decree issued by the minister in charge of health must be justified. As for their contents, they must be determined "in the interest of public health", "proportional to the risks incurred" and "appropriate to the temporal and geographic circumstances".

Moreover, while "the minister may authorize the territorially competent representative of the State to take all the necessary measures to apply these provisions", the exercise of these "health
policing” powers by the representative of the State is closely controlled. Indeed, it is stipulated that the public prosecutor is to be “immediately” informed of any individual measures, that the confidentiality of the data collected must be respected, and that the representative of the State must report on his action to the minister in charge of health.

The third ethical issue involved in the government’s plan concerns how to employ certain rare resources in the event of a pandemic (notably hospital beds, antivirals, masks and vaccines). The Joint Center for Bioethics emphasizes the need for a transparent process to define priority populations.

It can be regretted that the French plan does not establish such a list of priority populations, except regarding the use of different types of respiratory masks (cf. below).

References


[2] In his previously mentioned report, Jean-Michel Dubernard recalls that the requirement for the proportionality of police measures “was stipulated in a decree of the Conseil d’État in 1933 [Conseil d’Etat, May 19, 1933, Benjamin, “Lebon” collection, p. 541, http://www.conseilleat.fr/ce/jurisp/index_ju_l221.shtml]. As the government commissioner indicated at the time, using an expression often repeated since, “freedom is the rule, and police restriction the exception.” From a public health standpoint, this notion of proportionality, close to the evaluation of a risk-benefit ratio, is often used in public health regulation, notably for the evaluation of certain drugs. In practice, in the event of a bioterrorist attack it could lead the minister of health to recommend the large-scale prescription of a specific drug, for example a certain type of antibiotic.”
**THE GOVERNMENTAL PANDEMIC INFLUENZA PREPAREDNESS PLAN**

**A CALL FOR ETHICAL THINKING**

**ESSENTIAL VALUES**

Since 11 January 2006, the French Government has been working on a "Pandemic Influenza Preparedness Plan", which can be consulted at www.grippeaviaire.gouv.fr

The above-mentioned document contains a plan to prevent and control a possible flu pandemic. A number of measures specific to crisis periods are outlined, including the obligation to confine poultry and apply quarantines and appropriate health care strategies.

As the Governmental Plan currently stands, different points inevitably bring to light the difficulties involved in drawing up and applying such a plan.

Firstly, it should be remembered that these difficulties are due to an evident lack of thinking about ethical issues while the document was being drawn up. Drawn up in urgency, the Plan aims to provide an immediately workable solution to the consequences of a pandemic. However, it fails to look at possible ways of improving prevention and care based on in-depth thinking about the ethical issues at stake.

The main ethical values underlying the way care is dispensed are virtually ignored in the Plan.

It is only now that the Plan has actually been finalised that ethical thinking is being applied to governmental strategies to control a pandemic. However, it has to be underlined that these strategies have in no way been modified in relation to the ethical issues presented, while the absence of ethical thinking when the plan was being drawn up undermines the Plan’s operational legitimacy.

A whole series of improvements can be made following an analysis of the ethical issues. The objective of such an analysis would be to bring the Plan in line with the essential health care values applicable today and hence guarantee the plan’s effectiveness.

The following values must be taken into consideration and underlined prior to any decisions about how to combat a pandemic. Furthermore, such decisions must be justified according to these ethical principles and the result be communicated to the entire community of health care workers and citizens. These values concern participation, the state of emergency, proportionality and the upkeep of essential care values such as rules relating to rights.
This presentation comprises five parts to be developed over the coming months:
• necessary participation;
• qualifying the degree of emergency;
• proportionality;
• essential care values;
• maintaining legality

**NECESSARY PARTICIPATION**

The history of pandemics shows that no contingency plan can be effective if it has not first been accepted by the population concerned. As a rule, citizens’ buy-in to the proposed Pandemic Influenza Plan can only be obtained if there is far-reaching and intensive communication about the measures planned as well as a reminder of the ethical justification for each of the decisions taken and measures put forward.

**The need for extensive communication**

The fact that the Pandemic Influenza Preparedness Plan has been published on the Internet site concerned is worth pointing out. The set of recommended and implemented measures is provided in a detailed and intelligible manner. The site makes it possible to follow the pandemic as it develops along with the measures taken. It includes a lot of relevant and fresh information. Furthermore, information about each measure dealing with poultry confinement was widely circulated. All the media were involved in communicating this information, and the ministers were present when the measures were applied. A real effort to communicate could therefore be seen on this occasion.

However, it has to be pointed out that all the information is organised *a priori*, without taking into account the ethical implications of the actual measures planned or taken. Indeed, simply advertising the proposed measures is significantly different from setting up genuine effective communication involving a more educative and participative approach. In spite of the fact that a crisis is hypothetically possible, and in spite of the figures that are more than alarming, the obvious incredulity of our citizens has to be underlined. This scepticism with respect to a possible crisis therefore requires the right kind of anticipative communication as well as advance buy-in to the planned measures.

**Qualifying a situation as an emergency**

Public authorities’ involvement in the way health care is dispensed, beyond simply organising or planning the health care offer, is justified in a state of emergency, and only an emergency can justify modifying the established ethical rules. It is consequently necessary to determine the degree of emergency and the consequences of possible inaction in a precise, thorough and disciplined manner. This qualification may be based on a scale of contamination – from poultry to human beings – or the geographic spread of the pandemic. A state of emergency cannot be understood according to purely *quantitative* criteria however. Indeed, it

**The need for communication about ethical justifications**

The communication model chosen consists in providing information about essentially technical and operational points. Similarly, although the Plan is inspired by a desire to comply with the Law, the communication concerning it fails to mention the ethical issues. Thus, no analysis grid has been set up for decision-making. A number of ethical difficulties are at times mentioned, but these are handled by referring to existing legal provisions. Yet it should first of all be noted that several systems co-exist and must be subjected to an ethical assessment in view of the requirements of a pandemic, as they were not designed for a pandemic and may therefore prove to be inappropriate. Consequently, the governmental pandemic influenza preparedness plan must include communication about the ethical values that are essential for it to be accepted, for it to work and, finally, to ensure its quality.

Any Plan that does not take into account basic health values, on the one hand, and the community, on the other hand, will not readily succeed in obtaining the participation of the citizens concerned. The history of pandemics repeatedly shows that collective panic invariably prevents a Plan from being carried out effectively, owing to a lack of concrete anticipation during the preparation phase. Preserving the values of our society can ensure that the projected measures actually work. It is today essential to determine a grid for analysing the ethical values that are essential to the preparation and implementation of a pandemic influenza plan.
is also important to take into account all of the quantitative criteria to determine whether or not there is an emergency. This is why the transmission of a poultry pandemic to human beings calls for specific measures. The same applies, for instance, when an effective vaccine is discovered, which may lead to the need to develop an emergency vaccination strategy. Whatever the case, information about the emergency requires discussion involving several levels of expertise and according to different relevant territorial criteria.

**Different levels of expertise**

When the French law of 4 March 2002 relative to patients' rights and the quality of the health system was set up by the legislator, the aim was to introduce a genuinely “democratic health care system” involving the necessary participation of its users. The emergence of an avian flu pandemic underlines the fact that all citizens would be concerned by the health policy as the pandemic developed. This is why it must be possible to consult and mobilise the many bodies in charge of relations with users created inside and outside of health establishments, in order to confirm the existence of an emergency. Only by communicating with all citizens and getting them all to participate will it be possible to protect the common interest and protect the welfare of the community.

**Different territorial levels**

The different territorial levels concerned, moreover, must contribute to qualifying the state of emergency in order to ensure citizen participation. Only the Government has a centralised and relevant vision of national data about the pandemic. Nevertheless, and as outlined in the governmental Plan, all territorial levels must be mobilised: national, regional, departmental and intra-departmental. For each level concerned it is important to get administrative authorities involved as well as all formal and informal bodies of citizens. Similarly, although the French pandemic influenza preparedness plan seems to work in strictly epidemiological terms, the apparent lack of coordination between the French plan and the plans and measures implemented at European and world level makes an effective fight against the pandemic illusory.

**Proportionality**

Once a situation has been qualified as an emergency, suitable measures will be implemented within the framework of the preparedness plan. It follows that the criteria used to adapt these measures must be based on proportionality. When emergency action is required, proportionality involves checking that the planned measures are effective and minimising their consequences from a health, ethical and legal point of view. All exceptional measures taken during an emergency must consequently be specifically justified and their effects thoroughly assessed before they are implemented.

This applies to the limits imposed on basic freedoms and access to care, to the obligations imposed on healthcare professionals and on breeders to destroy their livestock, or to the obligation to ban access to cemeteries for health reasons, etc. Thus, proportionality first of all requires balancing the need for the measure with its consequences and then comparing its effectiveness with its cost. A measure may then need to be adapted before being applied in order to reduce risks without altering its effectiveness. The Plan must therefore take into account the importance of minimizing risks in all situations, by calling on all of the competent specialists and applying the appropriate ethical principles. Consequently, it appears essential to justify all the decisions and measures implemented by offsetting these against the risks incurred, both in the case action or inaction.

**Essential health care values**

In France, essential health care values are embedded in a wealth of historical, philosophical and sociological data, and a diversified legal system. They firstly reflect a minimum consensus according to which all the people concerned agree to provide or receive care. They also enshrine the objective to improve its provision or receipt, and therefore concern both health care staff and people suffering from disease. During a pandemic, matters are complicated as it becomes difficult

Indeed, simply advertising the proposed measures is significantly different from setting up genuine effective communication involving a more educative and participative approach.
to distinguish between people having recourse to health care and the others.

Health care workers

Should an influenza pandemic break out there are still many questions that remain unanswered. These concern the obligation to provide care, strategies for ensuring that medical personnel participate in dispensing care as well as the involvement of non professionals in the health system.

Health care workers are under the obligation to assist anybody in danger. A possible pandemic in no way changes the existence or content of such an obligation. Nevertheless, should a state of emergency arise, measures limiting individual freedoms may be implemented and may also prevent a health care professional from doing their job (if a district is quarantined for example). Similarly, the obligation to provide care is judged according to the measures taken to prevent the person from being exposed to excessive danger. Care professionals could therefore reasonably argue that their involvement would place them in danger, resulting in their de facto refusal to dispense care.

The obligation to provide care can therefore only be implemented through a prevention and treatment strategy targeting health care professionals first.

A health care strategy adapted to the health care profession implies a prioritization of urgent cases and needs for efficient care. Indeed, although from both an ethical and legal point of view it is not possible to give priority treatment to some rather than to others, health care professionals must be kept healthy if they are to continue to dispense care. It is a question of ensuring the common good. Failing this, if a service ceases to be provided this will lead to the interruption of care for many people and the inevitable spread of the pandemic. For these reasons, health care professionals must understand the risk and accept it so that they can obtain a guarantee that they will have free access to prevention and treatment.

Furthermore, it must be recalled that the risks incurred will have repercussions for their family, which could cancel out any willingness to get involved unless suitable care is provided.

Ethical reflection is therefore necessary to determine the possible need to set priorities and justify them on a case by case basis.

Finally, some health professionals who are no longer active may be called on to back up failing or insufficient services. It is surprising to say the least that in pandemic-free periods minimum skills are a pre-requisite, while health professionals no longer exercising their profession can be called on in a crisis. If the state of emergency necessitates mobilising everybody, suitable training must then be given since managing a crisis requires specific skills which some professionals may no longer have.

Patients

Many measures may be put forward, if not imposed on patients during a pandemic. These lead to essential individual freedoms being limited as well as health management that is adapted to the circumstances.

Limiting individual freedoms obviously still lies at the centre of many ethical questions linked to a pandemic influenza preparedness plan. Whatever the measures planned, all necessarily impose a restriction or suspension of liberties: confinement or slaughtering of livestock, quarantines for human beings, transmission of confidential health data to different authorities, obligation for health professionals to dispense care, obligation for patients to receive care, public requisitioning of different people, limiting patients’ right to care, limiting people’s movement, banning public meetings, border controls, etc.

Although these restrictions appear to be necessary, this can only be judged by carrying out a fair examination of the proportionality of the measures taken. If citizens do not participate in an informed manner and explanations are not provided, it will not be legitimately justifiable to call individual freedoms into question.

It is now necessary to carry out some in-depth thinking about the ethical issues behind the proposed measures in relation to the different values applicable to care. For although it is normally possible for patients to refuse care in a hospital, treatment designed to prevent the spread of the pandemic may be imposed on them.

When an influenza pandemic breaks out, the first phase obviously consists in organising the right kind of health care management.

The governmental plan aims first and foremost to keep people suffering from influenza at home. Indeed, when care centres are unable to accommodate all patients suffering from the disease, fair and satisfactory admission criteria must be drawn up, taking both health and ethical aspects into account.

An assessment of the means implemented must therefore cover the criteria already
mentioned, but also the ethical considerations that are currently absent from the Plan.
Before the pandemic appears, it is therefore important to ensure that bodies in charge of such reflection assess the possible limitations of public liberties, justify them and give them a framework based on a grid of fundamental values.

**Maintaining legality**

In a democracy it is essential to maintain legality. Nevertheless, planning traditionally includes the possibility of imposing limits or suspending public liberties in exceptional circumstances. Beyond the principle of proportionality, used to measure the appropriateness of modifying basic freedoms, it would seem preferable to limit recourse to such exceptions, apparently justified by the crisis.

Exceptional circumstances, i.e. the state of emergency, authorize the executive power to assume the prerogatives of the legislative power in certain situations. While this possibility exists in the French legal texts, recourse to it should not be necessary if one of the objectives of preparing a pandemic plan precisely consists in avoiding exceptional measures thanks to the efficacy of the proposed systems. Indeed, they confer on the Government or President of the Republic a huge amount of latitude, with no monitoring or guarantee that basic freedoms will be respected. Neither can it be taken for granted that a judge will accept the measures adopted during a crisis situation as being valid and suitable a posteriori. Our approach to the crisis period ahead must therefore be marked by a focus on the appropriateness of the proportionality principle in order to adjust the balance between the effectiveness of the measures taken and the essential justice required for their enactment.

With respect to scientific questioning, it also seems essential to shed light on some current principles whose emergence in the legal system has led to diverging viewpoints. Should a crisis be announced, a distinction will have to be made between what is linked to prevention in the light of known scientific data and what relates to precaution when there is scientific doubt. The respective field of application of these principles, but also their consequences, must be specified. For, beyond strictly theoretical discussions, they provide a legal framework for intervention in different situations and, consequently, differing intervention ethics according to the situations.

The different points discussed in this paper will undoubtedly be taken up and developed further once those in charge of the governmental plan agree to present the ethical principles behind their resolutions.
LEGAL AND ETHICAL ISSUES

WHO checklist for influenza pandemic preparedness planning
Department of Communicable Disease Surveillance and Response Global Influenza Programme,
World Health Organization, 2005

"The aim of the pandemic preparedness checklist is primarily to provide an outline of the essential minimum elements of preparedness, as well as elements of preparedness that are considered desirable. It is recommended that responsible authorities or institutes in countries that are in the process of planning should consider the specific aspects of the checklist for which they are responsible. Countries that already have a national pandemic preparedness plan in place may use the checklist to evaluate the completeness of the current plan."

Preface, excerpt

EXCERPT OF THE DOCUMENT

1.5 Legal and ethical issues

1.5.1 Legal issues

Rationale

During a pandemic, it may be necessary to overrule existing legislation or (individual) human rights. Examples are the enforcement of quarantine (overruling individual freedom of movement), use of privately owned buildings for hospitals, off-license use of drugs, compulsory vaccination or implementation of emergency shifts in essential services. These decisions need a legal framework to ensure transparent assessment and justification of the measures that are being considered, and to ensure coherence with international legislation (International Health Regulations).

Questions to be addressed

Is there a legislative framework in place for the national response plan? Does this framework include contingencies for health-care delivery and maintenance of essential services, and for public health measures to be implemented? Legal issues that are highlighted in other parts of the checklist are brought together as a separate checklist here. Other issues are added.

Check

• Identify the advantages and disadvantages of declaring a state of emergency during a pandemic.
• Each jurisdiction needs to assess the legal basis of all public health measures that are likely to be proposed, including:
  - travel or movement restrictions (leaving and entering areas where infection is established);
  - closure of educational institutions;
  - prohibition of mass gatherings;
  - isolation or quarantine of infected persons, or of persons suspected of being infected, or persons from areas where pandemic strain influenza infection is established.
• Assess standing policy on, and legal basis for, influenza vaccination of health-care workers, workers in essential services (see sections 5.1 and 5.2) or persons at high risk. Decide if this policy needs refinement to increase uptake during pandemic alert and pandemic periods. Consider the use of both seasonal and pandemic vaccine for these groups.

Full text available at:
http://www.who.int/entity/csr/resources/publications/influenza/FluCheck6web.pdf
• Address liability, insurance and temporary licensing issues for retired health-care workers and volunteers who may be working in areas outside their training and competence in health and emergency services.

• Consider liability for unforeseen adverse events attributed to vaccine and/or antiviral drug use, especially where the licensing process for a pandemic strain vaccine has been expedited. Liability issues may affect vaccine manufacturers, the licensing authority and those who administer the vaccine.

• Ensure a legislative framework for compliance with the International Health Regulations.

• Consider including influenza or pandemic influenza in national legislation for the prevention of occupational diseases.

1.5.2 Ethical issues

Rationale
Ethical issues are closely related to legal issues as mentioned above. They are part of the normative framework that is needed to assess the cultural acceptability of measures such as quarantine or selective vaccination of predefined risk groups.

Questions to be addressed
Have ethical aspects of policy decisions been considered? Is there a leading ethical framework that can be used during the response to an outbreak to balance individual and population rights?

Check
• Consider ethical questions related to limiting the availability of a scarce resource, such as rationed diagnostic laboratory testing, pandemic strain influenza vaccine or antiviral drugs.

• Consider ethical questions related to compulsory vaccination for healthcare workers and workers from essential services.

• Consider the ethical issues related to limiting personal freedom, such as may occur with isolation and quarantine.

• Ensure the establishment of an ethical framework for research, especially when this involves human subjects.
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### The Liberal Views Faced with a State of Exception

**Reflections on a Pandemic Influenza**

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**Considering the Notion of Emergency**

Among the dangers linked to an influenza pandemic, two appear very clear from the outset: the impossibility of applying the adequate measures and the necessary arbitrariness of their application. Depending on whether one is concerned by the first or second danger, one will wear the armor of a political and utilitarian realist or that of a defender of human rights and democratic integrity. Can we not choose between arbitrariness and a health disaster? Does the only choice lie between violating fundamental rights and having our hands tied? At the heart of this dilemma, it is the status of the state of exception that is at stake. It is understood as a more or less strict restriction of public liberties and a challenge to the separation of powers to the benefit of the executive power in the event of serious danger.

The weakness of liberal approaches to the possibility of a flu pandemic lies in the fact that, in their more or less open refusal of a state of emergency or "state of exception", they abandon the elaboration and justification of such a state to the political realists, thereby isolating themselves in pointless denial and causing democracy to run the very risks they wish to protect it from. It should be noted here that the paradox of this attitude is that historically the state of exception has been considered the only way to save "ordinary" government: it is above all a democratic, republican invention and thus should not appear alarming in itself, even if it does pose a certain number of problems. It would in any event be wise to encourage liberalism to comfortably take ownership of this concept if we want to avoid abandoning it to the predictable excesses of the realists.

Pasquino distinguishes between two main types of thinkers with respect to the state of exception: monists, for whom there is no difference between "ordinary government" and "exceptional government", and dualists, who "proclaim that the "norm" and the "exception" are two different conditions of the normative system" (p. 18). Among the monists he also makes a distinction between those who refuse this difference "because it would be possible to reduce it to the legal rationale of ordinary government" (p. 13) and those who identify any government action and the principle of national security measures as the supreme law, i.e. the absolutists (Hobbes, for example). We believe that the greatest danger is to reduce the liberal and democratic point of view to the naïve optimism of the first type of monist, as though this were the best way of avoiding the second type.

We can also distinguish two positions among the dualists. The “ontological” one that bases this dualism on an objective and easily recognizable state of the world called "emergency", and the
“epistemic” or “skeptical” position, more cautious about the obviousness of this situation and tending to believe that there could be some disagreement on its qualification. This skepticism implies that “one must assign to an actor of the political and constitutional system (body or institution) ‘the epistemic authority or competence’ to declare the existence of a state of emergency”. (p. 18-19). One could debate this last distinction and at the same time examine the status and methods of a health watch in the case of avian flu, but this is not our aim here. It is rather more important to observe that these two dualisms avoid the trap laid by naïve optimism. Indeed, by believing that the exceptional can be made ordinary, naïve optimism prevents thinking about the emergency: the emergency category has no meaning for it and, to be blunt, pandemic or not, it’s all the same; it therefore lacks an object. These dualisms also avoid the trap laid by the absolutism of the second monism which in a way generalizes the notion of exception.

The application of democratic principles

This first stage is essential since it allows the recognition of the evidence of the state of emergency, which is both the recognition of an emergency and a refusal of absolutist authoritarianism. It is of course up to democratic liberalism to take ownership of this recognition to prevent it from being simply rhetoric. There are many ambiguities linked to a liberal position that refuses to suspend certain constitutional guarantees. A state of exception is defined by the possibility to disregard certain fundamental rights and to blur the separation of powers. It is therefore useless and counterproductive, even if it stems from the best intentions, to pretend that fundamental rights must be respected in the case of an influenza pandemic and that the executive powers must not encroach on legislative ones. This would mean refusing to recognize the specificity of the situation, denying the pandemic (somehow believing that the forecast of 1 to 2 million deaths and 0.04 to 2.7% of hospitalizations in Europe, the possibility of having the army protect hospitals, drastically limiting travel, etc. are characteristics of a situation to be managed normally...), i.e. preventing effective management of the situation and leaving the field free for all types of excess since their message will certainly not be heard.

From this standpoint, certain arguments are dangerous and even deceitful. We cannot, for example, recommend transparency and involving citizens in decision-making in all circumstances. Indeed, defending this idea is to identify the exceptional situation and the normal situation, to confuse the executive and legislative at a moment where they need to be distinguished to the benefit of the former. As in “skeptical” dualism, one must count on a body that can make rapid decisions alone.

The liberal reflex could then be to say that nothing can guarantee the legitimacy of decisions made this way. It is just the opposite, but two levels have to be distinguished. In a state of emergency, the question of the legitimacy of a decision is not raised, and is even what characterizes this state. The question is not whether the decision taken in a state of emergency is legitimate, but rather whether the state of emergency itself is legitimate. For example, one of the trickier problems during a pandemic will obviously concern quarantine and house arrest. Quarantine is a measure that contravenes fundamental rights and it is legitimate to discuss its application methods. It would however be unrealistic to abstain from having recourse to it. One can imagine the harm of such a measure: a healthy person would run a high risk of being in contact with sick people, so it should be envisaged in certain cases, as often as possible, to individually isolate people. However, recognizing a suspensive right of appeal would be irresponsible, since it would make it impossible to contain the pandemic. This example is perhaps a bit simplistic and no theoretician, even very liberal, would defend the possibility of appeal. Yet certain liberal petitions lead people to believe this and that is just what must be avoided. It basically boils down to not confusing democratic discussion on the nature of a state of emergency, before the state of emergency (only way for it to appear legitimate to citizens), with the application of normal democratic principles to decisions made during the state of emergency.

The question of legitimacy

The ambiguity of the liberal viewpoint can therefore be presented in a temporal fashion: it applies principles to the state of emergency that are only valid before the state of emergency. Yet this temporal confusion is based, as we have
tried to show, on a certain denial of the validity of the category of “exception”: it is its monism that condenses time. Once this is understood, we can try to face these difficulties more serenely. Indeed, the situation is rather encouraging.

Firstly, it is crucial to make the effort to discuss the exception before it is too late. We need to raise the question of legitimacy today, not when a pandemic has arrived, and it is not yet too late. Secondly, the liberal viewpoint, though it sometimes appears confused about these questions, is impregnated with elements that it sometimes refuses. One of the most powerful liberal arguments regarding the problem of legitimacy is that measures will be ineffective and therefore considered illegitimate if not accepted by the population. But this is not an ethical argument; it is a utilitarian argument par excellence! The necessity of ethical reflection bringing together medical actors, politicians and citizens is fundamentally a realistic and utilitarian necessity. Liberalism must simply be aware of this and not lock up inside the substantiality of its principles. It will thus give itself the means of preventing authoritarianism (the second monism) from occupying the field of realism on its own.

Thirdly, it is certain that the state of exception is only a stopgap, yet it is possible, before it actually becomes necessary, to limit it to the strict minimum. Indeed, it is supposed to allow fast action in unpredictable situations. Yet, it is possible, through expertise, consultation, institutional construction, and moral and political philosophy to cover a maximum range of future situations. If we imagine the field of political action as a straight line, we can attempt to keep to a minimum the segment that isolates the exception. In order to do this, as we have tried to show, one must accept to consider this segment in which reigns, in a very regimented way, pure political decision.

Finally, one could consider that the liberal refusal to accept the exception is linked to the idea according to which it would be a state in which human and civil rights are not respected and therefore would be uncontrollable. Yet there are many measures that allow us to eradicate this preconceived notion. We will mention a few to conclude. Similarly to the Roman dictatorship, and in opposition to Schmittean analyses, it is perfectly conceivable that the body that exercises the exceptional powers not be the same one that proclaims a state of exception. To avoid any abuse, it is also conceivable that, once the emergency is over, a jurisdiction be able to judge the decisions made during the emergency situation (based on proportionality criteria for example).

During the crisis, there is nothing to prevent a certain administrative control. Certain legal guarantees can be proposed, such as being able to recover one’s job after a period of quarantine for instance. Damages could also be paid to those who were wronged by certain decisions.

Recognizing the exceptional character of a pandemic and admitting that exceptional measures must therefore be implemented are not the obstacles but the conditions through which a specific democratic control may be exerted. Liberal views cannot refuse to accept the notion of exception and a certain decisionism in its thinking (which should not be identified too quickly as arbitrariness). Thankfully, these conditions are also those of legitimacy and of the effectiveness of such views.

References

[1] Though it refutes, through the notion of “police”, the normality/exception dichotomy – but in our opinion, only to avoid the fear linked to the notion of exception (more for strategic than theoretical reasons) – Antoine Garapon’s approach seems very close to ours, but as applied to terrorism. Cf. “Les dispositifs antiterroristes de la France et des États-Unis”, Esprit, 08-09/2006, pp. 125-149.

Recognizing the exceptional character of a pandemic and admitting that exceptional measures must therefore be implemented are not the obstacles but the conditions through which a specific democratic control may be exerted.
THE ETHICAL PERSPECTIVE

The public authorities’ efforts to prevent a possible flu pandemic must include an approach to the ethical issues, based on the contribution of various experts. This postulate, on which the mission of the Observation & Reflection Platform on Pandemic Influenza, Ethics and Society is founded, should be explained before even listing the different problems. What can an ethical view of the avian flu threat actually contribute? What is at stake?

On the contrary, in the face of a health threat as much as with other arbitrations of community life, the ethical stance consists in placing people at the very centre of the system designed to administrate them, both as objects and as subjects.

• As objects: since the ethical viewpoint underlines the humanity of those who are supposed to be cared for – a humanity that is considered primordial, irreducible and unavailable. In this sense, ethical discourse focuses on the anthropocentric absolute, according to which it is not possible to apply the same rationality to leading a group of human beings as to leading a herd of animals or to the economy of material things, whatever material advantage this may afford. Nor is it possible to apply the criteria used to decide the fate of a piece of property to an individual.

• As subjects: since the ethical viewpoint is in fact the view that humanity has of itself, as it searches for its own salvation. According to this meaning, taking care of other people as human beings means applying one’s own humanity and inviting others to share a common humanity.

It is not just a question of adding a little extra soul to the pragmatic risk management already set up, where applying the right technical solutions, discipline and efficient administration are all important. Neither is it a question of wrapping up technocratic solutions in communicational packaging – the current version of the extra dash of soul – to ensure they are easily digested by the general public, i.e. by the populations to be protected. Such an objective aims to raise awareness, educate and reassure, and is reached by rhetorical rather than ethical means, even if the former, as experience shows, may usefully back up the latter.

THE ENDANGERED CITY

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ethical discourse offers a perspective on things. In this respect, it challenges decision-makers and enjoins them to set up the necessary balance between the humanity of the citizens they are responsible for and their own humanity as subjects able to make decisions. Similarly, it challenges the citizens themselves. According to good ethical reasoning, if those for whom decision-makers decide are people, they are as such co-subjects and not simply objects of the decision. It is the same humanity that strives for recognition both before and after a decision is enacted: humanity of authority and humanity of essence are indiscernible, as are enlightened authority and “love of humanity”.

THE ENDANGERED NATION

Making decisions for citizens that include an ethical viewpoint thus involves allowing those who are the objects of a policy to become the subjects too: for instance, by inviting citizens to participate in the search for solutions and counting on them to promote these.

Among the issues surrounding a pandemic, the common logic of ethics and democracy encourages us to think about the influenza threat according to the historical paradigm of the endangered nation. Including the ethical stance in a prevention policy means mobilising citizens to defend a city whose salvation guarantees recognition of their humanity and their rights. Reciprocally, this ethical stance is the only one that makes it possible to believe that the endangerment of the city is the personal affair of all citizens. Without this intimate relationship, set at the very heart of the social pact, between the responsibility of each individual and the common good, the logic of disaster cannot be countered, even with the talent and efforts of decision-makers. Some useful input to this subject can be found in book II (47-54) of The Peloponnesian War by Thucydides, relating the events of the Athens plague, and the first book of The City of God by Saint Augustine, drawing on the lessons of the recent sacking of Rome by the Goths (410).

Although it is the only viewpoint able to capture the entire energy behind the social pact, the ethical and democratic viewpoint is often portrayed as weak, or at least having a weakening effect on decisions. It is therefore important to demonstrate its power. How can the dual goal of ethics and democracy be maintained alongside the requirements of health and administrative rationality? What conditions will this imply? This is what the work of the Observation & Reflection Platform on Pandemic Influenza, Ethics and Society will strive to elucidate.

Reference

Setting up dialogue to meet the challenges of the crisis

Interview with Jean-Marie le Guen
MP for Paris, President of the Avian Flu Information Mission, National Assembly
Interviewed by E. H.

Diagnosis

Emmanuel Hirsch: In the foreword to the recent report of the National Assembly (23 June 2006) – “Pandemic plan”: crisis strategy, which constitutes the third part of the work of the Avian Flu Information Mission: preventative measures –, you publish your letter of 12th June 2006 to Jacques Chirac. Why did you write to the President of the Republic?

Jean-Marie le Guen: I wanted to support a policy that is being set up in progressive stages by giving public exposure to some of the issues at stake. Since October 2005, there has been a step-up in the procedures presented for planning purposes, but also with respect to various communication initiatives. And yet, there is one stage that has still not been reached: that of society’s buying into the management conditions of a possible pandemic.

Let us take the diagnosis stage. There is still a lot missing from the recommendations laid out in the governmental plan, notably when it comes to local authorities, infrastructures and, more generally, the health offer. I believe there are two main reasons for this. Firstly, when faced with any public health issue, there is a temptation to look for solutions that are above all medical and technical, when we know that the problems arising most often relate to social organisation in the broadest sense of the term. Secondly, there is the difficulty of dialoguing with the people most likely to be involved about their rights and their duties. So, for the professionals most likely to be more exposed to a risk of contamination, what guarantees can we provide them? What support can be offered should they fall ill? We must talk openly about the realities of a possible pandemic. This is not what is currently happening and this is something I regret. The parliamentary mission has made it possible to take a more objective approach to the threat.

E.H.: In your letter to Jacques Chirac, you express the following opinion: “I do not think that the commitment of the professionals concerned, starting with those working in the health sector, should be taken for granted. The fact that some professional categories likely to be mobilised have a more or less precise legal framework organizing their work is not a solid enough guarantee if the ethical stakes are not asserted and practical provisions ensuring their own protection are not set up. We must be specific about the type of public service mission we expect from these different people as of now.”
Let's move on to your recommendation: "We need to prepare our fellow citizens to be the main actors in the primary vigilance system. The pandemic will be less a major health crisis than a significant test of social cohesion. It is by developing active solidarity based on proximity that trust will be born.

J.-M. le G.: We must be transparent, accountable and supportive. The French people have understood this with the principle of precaution. Today, we can plan for a crisis, which may prove to be disastrous if nobody gets involved. Without being overdramatic, the situation needs to be explained, which is a delicate operation given the lack of genuine scientific culture. Each individual must decide on his or her role and feel that, in the event of a pandemic, suitable and applicable solutions have been planned. The situation of particularly vulnerable people must be fully taken into account, based on the initiatives set up following the heat wave of 2003. If this is not done, you can imagine how disastrous the situation might be. The Katrina phenomenon should act as a wake-up call for us to be more vigilant.

It is not so much the Governments that are being challenged as society itself. Society must be given the means to resist new threats. What's new this time is the way we view these risks. We have the scientific ability to plan ahead for them, but also, with the help of the media, to observe and measure them across the globe. Preparing ourselves involves doing everything possible to foster our resilience. The issues thus come across as very modern. Furthermore, the State cannot continue to simply watch over...
what is happening: everybody must feel accountable. We must have the courage to challenge society, across its range of different components, and to thereby come back to the fundamentals of democratic life.

E.H.: Did you receive an answer from the President of the Republic?

J.-M. le G.: Yes, in a letter of 22 June. Let me cite a few extracts.

“Although I share your diagnosis of the need to find a solution to the health risk based on social order, I do not believe that this approach should take priority. Given the epidemic risk, there must be a dual solution: both medical and social. [...] You are right to underline this; the social and ethical stakes involved in fighting against the risk of a pandemic are huge. Public authorities must combat the temptation to deny such a risk just as much as the temptation to panic. It is also their duty to promote individual behaviour combining individual responsibility and collective solidarity and to do everything possible to encourage unfailing commitment from health professionals. This is exactly what the Government has undertaken to do.”

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The Masters in Ethics, Science, Health and Society has been developed by the Research Department in Ethics of the University of Paris-Sud 11, in partnership with the Espace éthique / AP-HP. A new culture of ethical reflection is underway. Promotion of this new culture implies gathering and disseminating knowledge, as well as developing research dedicated to exploring ethical concerns in scientific practice as well as within other related professional activities, notably in the delivery of healthcare services.

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# Public Health

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A historical perspective on epidemics and public health

Public health measures and acceptability

For Jean-Noël Biraben, referring to the example of Italy, "the first elements of a public health policy can be found in Italian cities after the terrible plague epidemic that swept through the peninsula in 1347, giving rise for the first time to a host of new measures of an exceptional amplitude."[1]

We can confirm, with very little doubt, that our national and international health systems result from a certain contagious determinism: indeed, the fight against epidemics gave birth to most public health structures, and the various epidemics occurring over the centuries significantly impacted health security policies. In 1429 in Barcelona, a series of minor epidemics obliged the Council of One Hundred to implement administrative measures. To "measure the real importance of the disease and end all rumors, civil servants were entrusted with recording the number of deaths every day, indicating how many were due to the plague. In 1439, food supply was organized during the plague. Subsequently, trade was prohibited with locations reported to be infected, visitors from outside were denied entry to the city, and the sale of property and furniture belonging to people stricken with the plague was suspended. It is possible that a crude sanitary cordon was also drawn around the province."[2]

Implementing measures in the face of an epidemic nevertheless requires the population’s acceptance. For example, during a plague epidemic in Marseille in 1720, the population refused the anti-contagion measures proposed. Because "the notion of contagion was not unanimously accepted. (...) Trade ruled the city; therefore delaying the arrival of goods to Beaucaire, blocking the ships in quarantine, which meant immobilizing them for no reason and having to feed their crews, this was all expensive and yielded nothing!"[3]

We can see that any preventive or protective measure or action must be accepted by the population, whether professional or not, to have a chance of succeeding in practice. Nevertheless, epidemics undoubtedly encourage the emergence of specialized structures: "Despite the undeniable panic that it provoked, the plague also gave rise to the first rational, effective health measures applied in Europe."[4]

Thus a Superior Health Council was instituted in Constantinople in 1839, followed and completed by the Health Council in Tangiers in 1840, and the Quarantine Council in Egypt in 1843. A Pan-American Health Office was set up in 1902, devoted mainly to yellow fever prevention. These widely dispersed

Implementing measures in the face of an epidemic nevertheless requires the population’s acceptance.
structures and knowledge were then unified in 1910 under the aegis of the International Public Hygiene Office, which subsequently became the World Health Organization in 1945.

**CONTROL AND DISCIPLINE**

Hospitals also offered protection from epidemics, since some of them served as a refuge for the contagious: "As in other cities, it was decided to transfer and isolate the plague-stricken in special establishments. These hospitals, "lazarets" "sanitats", or "santés" as they were called in many locations in France, were multiplied in the 15th and 16th centuries and even in the early 18th century, as illustrated by the Saint-Louis Hospital in Paris. Special areas were set aside in pre-existing hospitals, abandoned convent buildings or leper-houses were recovered, and sometimes new buildings were built that remained empty when there was no epidemic."[5]

In the 17th century, to measure the extent of the disaster caused by the plague, the English administration began to count the number of births and deaths in each parish, thereby inventing health statistics and demography. A century later the King’s intendants in the French provinces were obliged to regularly inform their minister of eruptive fevers and plagues as well as epizooties and famines. Along the same lines, Michel Foucault explains the structuring impact of the plague on health security. Faced with an epidemic and the troubles it caused, he writes that medical authorities responded with what he calls "discipline", a central concept in his work. "The plague is met by order, its function is to sort out every possible confusion: that of disease, which is transmitted when bodies are mixed together; that of evil, which is increased when fear and death overcome prohibitions. It lays down for each individual his place, his body, his disease and his death, his well-being, by means of an omnipresent and omniscient power that subdivides itself in a regular, uninterrupted way even to the ultimate determination of the individual, of what characterizes him, of what belongs to him, of what happens to him. (...)The plague as a form, at once real and imaginary, of disorder had as its medical and political correlative discipline.[6]"

Discipline as a system to analyze the confusing, as a means to remedy the vague, as a combat technique against infection, itself consecutive to disorder. Epidemics have marked the history of mankind and, through pain and suffering, have introduced measures of control, separation and discipline.

**We can see that any preventive or protective measure or action must be accepted by the population, whether professional or not, to have a chance of succeeding in practice.**

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Part of society’s response to a possible flu pandemic involves making sure that hospitals are prepared to manage patients suffering from a serious form of flu. However, hospitals will only be effective if they harmoniously cooperate with general practitioners, who according to forecasts will be in charge of treating a very high proportion of patients suffering from flu (as much as 80%). Likewise, their operation must also tie in with other sectors of society: transport, supplies, economy, etc. The development of the hospital pandemic influenza preparedness plan has brought to light many questions about the way health structures ordinarily operate.

Following time spent preparing the pre-pandemic phase, the steering unit (to which we currently belong, but which is not the subject of this paper) commissioned three working groups to focus on pandemic preparedness: central coordination, Co-Victoria; liaison with pre-hospital care; organisation of hospitals. Broken down into several sub-groups according to theme, the Hospital group is made up of professionals from the different disciplines concerned – infectious diseases, respirology, intensive care, hygiene, virology, etc. - , from different hospital sites in the Ile-de-France region. It thus brings together different types of actors – administrative staff, doctors, caregivers, technicians, etc. The interdisciplinary nature of the group was seen to be especially important when addressing the difficult issues and uncertainties in to the plan set up by the government.

And although some might think that it is sufficient to trust the ability of health professionals to adapt – and it is clear that this confidence between actors is essential in a crisis – the potentially wide-reaching social disorganisation brought on by a pandemic is an argument for those in charge to become fully committed to the preparation.
relating to planning as it provided different viewpoints and hence strengthened the group’s collective expertise. Making it possible to share knowledge and foster recognition for others’ work, it also proved to be essential in encouraging reciprocal respect, a determining factor when activating a network made up of different professional groups in a crisis.

Early on in the process the importance of promoting interactivity between the steering group, working groups and professionals in the field was felt. Multi-directional information exchanges were encouraged, in several stages, in order to trigger reflection in the many monitoring units and working groups on the sites. The steering unit provided a common framework to ensure that thinking was extended and fine-tuned thanks to the work carried out on each site. The findings were then collated, summarised and re-circulated by the steering committee so that they could be shared by all. This interactivity makes it possible for each person involved to adopt a well-defined role before having to face the crisis.

The content of the preparatory work focussed firstly on apparently technical themes: adapting hospital activity, mobilising staff, logistics, safety, etc. A certain number of principles and recommendations were drawn up. These concerned the distinction between zones with a high or low viral density, the definition of a dedicated reception area, de-programming of certain activities, redeployment of staff, mobilisation of “back-up” staff, setting up of stock, ensuring hospital safety, etc. They brought to light the substantial tensions in an epidemic between preserving individual interests and collective interests against a backdrop of anxiety, if not collective panic.

**AN INEXHAUSTIBLE SOURCE OF QUESTIONS**

Perhaps the first question concerns the effectiveness and consistency of the organisational work linked with that of the groups set up within the different public authorities involved. What approach should be adopted when dealing with apparently contradictory and overlapping proposals? And yet are these not a source of critical analysis likely to trigger new ideas? Keeping a close track on developments, touching base at regular intervals, ensuring sustained vigilance and responsiveness and being genuinely available can help to shape and effectively structure the profusion of ideas.

The second question concerns how to first mobilise health professionals and then the citizens or potential users of the re-organised services. How can we prevent people from shaking off their social responsibilities – notably in the hospital system – while at the same time making sure they are able to shoulder their own personal responsibilities with respect to their families, friends and colleagues? How can we explain the notion of “staff who are essential” to the continuity of social life? How can we ensure that the protection of these people (by providing masks, vaccines and anti-viral drugs) takes priority so that they can do their jobs and, in so doing, provide the best access to continuing care and enable society to continue to be active?

The economic stakes appear to be a source of major conflicts of interest between the public and private hospital sectors. How can the load taken on by each be fairly balanced? What organisations, what protection systems should be set up so that when health resources are limited owing to a major pandemic, the most vulnerable members of society do not pay the highest price in the health crisis?

Even the most highly involved in pandemic preparedness have difficulty imagining how the crisis will be managed over time. Of course, we have white papers to help us face generally “severe” crises. But these do not take into account the problem of duration. “Pandemic” addenda to white papers are currently being drawn up… But how is each actor and each organisation going to rethink their relationship with time in the event of a pandemic? Some in-depth preparation still has to be done in order to tackle this issue.

Finally, debates about training, information and communication are only just beginning. How should hastily acquired and non-validated knowledge be passed on? How can we create

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*Even the most highly involved in pandemic preparedness have difficulty imagining how the crisis will be managed over time.*

*As already underlined, preparedness is a determining factor for strengthening social links and hence fostering cohesion among health professionals and the people they have to deal with.*
common knowledge that is based on ideas with different and sometimes arguable levels of scientific proof as well as genuine field experience? How can we take into account the ignorance of leaders with respect to certain, apparently impossible, choices (for example the prophylactic use of antiviral drugs on health personnel)? How can we promote transparency, so that the planned measures are applied, and prevent people’s anxiety from escalating and hence generating irrational and unsuitable reactions endangering individual and collective safety?

At this point, we can simply emphasize that, however complex, taking such questions into account during the preparatory phase can only facilitate hospitals’ ability to adapt to a crisis, and pave the way to finding solutions to new questions that are bound to emerge in the process. As already underlined, preparedness is a determining factor for strengthening social links and hence fostering cohesion among health professionals and the people they have to deal with. It is a means of structuring organisations that calls for setting up a new type of hospital governance.

### CONSIDERING RESTRICTING ACCESS TO INTENSIVE CARE

Marc Guerrier  
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### REGULATING AN EXCEPTIONAL SITUATION

Performing intensive care on persons suffering from severe or complicated forms of influenza during a pandemic potentially raises a major problem: there may be a shortage of resources[1]. Measures aimed at increasing the possibilities for ventilation (equipment, qualified persons, etc.) are already planned or are being rolled out. Nevertheless, the possibility of being in a shortage situation must be envisaged and all of the ethical questions that this may raise must be addressed. Several colleague intensivists abroad, in particular in Great Britain, the United States and Israel, have brought up the necessity of examining early on the new challenges represented by the material impossibility to provide intensive care to all who should receive it[2-5].

Two main types of positions could be adopted in view of such an advance reflection. The first consists in asserting that the tools used to decide whether or not to admit a person into intensive care during a pandemic, including in the case of the ward’s inability to respond to a much higher demand, should be the same as those used today. From this standpoint, order of arrival becomes an important criterion since it conditions admission into intensive care or not of persons in health situations for which resuscitation would be beneficial. For admission into

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**Reference**

[1] The Hospital group is coordinated jointly by Jean-Baptiste Haggenmuller, assistant manager, Saint-Antoine university hospital centre, AP-HP, and Dr Marie-Laure Pibarot, Emergencies-Health Risks mission, AP-HP.
intensive care, the technical instructions in the French government’s plan use medical severity criteria without any additional restrictions.

The second position is one in which we plead for an adaptation to the decision-making procedures for admission into intensive care under “normal conditions”, i.e. excluding during a pandemic. This entails establishing exceptional regulating methods, calling on additional factors that will necessarily lead to refusing access to intensive care to certain persons who would have benefited from it under other circumstances.

Many arguments support the necessity of this type of anticipation and of the transparency of the debates that ensue. To mention just three: it contributes to averting potentially illegitimate decisions, to guaranteeing equity during a public health crisis, and to anticipating the care that must be dispensed to those who will not have access to intensive care despite a medical condition that justifies it.

Adopting the second position brings to the foreground three tricky questions: the question of decision-making responsibilities; the question of the nature and legitimacy of the common base of objective criteria that should be used (in order to guarantee equity in resource distribution decisions); and the question of the nature of the care and support given to those persons who are not resuscitated.

TO INTENSIVE CARE: A PRACTICAL RESPONSIBILITY

As concerns decision-making responsibility – and by this I mean the responsibility of deciding who will and will not be resuscitated – there are two possible conflicting approaches for health care professionals.

The professionals may, through a desire for autonomy, claim the responsibility for distributing care according to their available capacities and to a modified decision-making process (relative to references from non-pandemic periods). They themselves assume the responsibility for the selection made from amongst those needing their care. In this position, the tension existing between the responsibilities incumbent upon the health care workers to society, on one hand, and to individuals, on the other hand, as well as the dependence of the latter on the former, are integrated by health care professionals in their decision making. The integration of this constraint by competent professionals also makes them actors in public health, and autonomous within a normative framework with modified references.

The second possible approach to decision-making responsibility consists in freeing the intensive care actors from taking the decision whether or not to provide care to a person who might need it. This would mean that the decision to admit a person into intensive care or not would be made by a third party, whose role is to apply the standards established for selection in an ideally neutral and independent manner. The professionals in charge of intensive care would therefore not be involved in the triage process and would care for the people entrusted to them after upstream management. The public health function of distributing health care resources and the function of providing intensive care in the interest of the person are thereby separated.

WHAT CRITERIA SHOULD BE USED TO ESTABLISH A SELECTION?

The nature of the criteria to be used raises a difficult debate. For Pesik[6] — in work dedicated to medical triage in the context of a terrorist attack — criteria not related to the expected collective medical benefit must not be taken into account. Hence, for example, age, ethnic origin, gender, socio-economic status or the existence of other illnesses not affecting the short-term prognosis must not enter into consideration as such in the decision whether or not to begin the use of a limited medical resource. He argues that the decision should be based on a principle of proportionality in terms of the individual benefit for the person, taking into account the amount of resources required: “Practitioners must prioritize intervention to those who will benefit most from the fewest resources.” The group of persons that will benefit from care will be determined by the combination of three factors: the expected medical benefit for the person, the evaluation by the professionals of the proportionate nature of the consumption of resources required for each case, and the order of arrival of the persons (all of the cases cannot be examined simultaneously).

Pesik’s analysis is appealing, particularly since the principle of non-discrimination is very important for populations normally vulnerable to various types of stigmatization. At the same time, we
must observe with Childress[9] that the distribution of limited resources in an emergency health situation must not lead us to state that no discrimination will take place — it will well and truly be impossible to care for everyone — but to think about what is the least unacceptable discrimination or the most justifiable.

One of the limiting factors for possible severe forms of a pandemic influenza will be the number of available respirators (and trained operators). Hick puts forward an opinion similar to Pesik’s in a collective paper that aims at establishing “Concepts of operations for triage of mechanical ventilation during an epidemic”[8]. Utilitarian reasoning (totally medical here since only based on the expected effects of the treatment) applied to restricting the use of mechanical ventilation is used while taking into account the dynamics of the epidemic. Indeed, the severity criteria and the use of the proposed severity scores (in order to evaluate the prognosis and therefore the validity of resuscitation) must allow the decision to use a respirator to be made. Nonetheless, this author feels that the quantitative thresholds used must be adapted in real time according to epidemiological data, so that if the number of the sick decreases, the threshold values can be made more permissive for intensive care admissions. Conversely, a large increase in demand must lead to a restriction in the intensive care admissions rate.

In the extreme, the application of this type of reasoning can lead to stopping the resuscitation of a person whose quantitative predictive indicators have fallen below the accepted threshold, either because the person’s condition worsened or because the threshold was modified due to the increase in the number of patients potentially needing a respirator (even if the person’s condition is improving). Hick’s proposal stems from an entirely medical reasoning based on the predictive values of severity scores. It leads to rethinking not only the admission approach but also potentially the decision-making processes to continue or stop care.

Other reasonings can complete this expected medical utility by taking into account non-medical factors. This is the case of utility or social value in a “strict sense”[7]: recognition of a skill and the necessity to continue to harness it during the medical emergency. It is precisely this pragmatic approach that government plans are adopting to give priority access to prevention and care to health care professionals.

Finally, it is also possible to object to the primacy of medical utility reasonings as does Emanuel[9] for vaccination – the adaptation of his approach intensive care would lead to focusing efforts and resources in priority on people roughly between the ages of 10 to 50, without adding restricted access intensive care for them (cf. in this issue of Pandemics “Who should be vaccinated?” p. 74).

The criteria for a possible triage of intensive care treatment have not yet been subjected to public debate in France.

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The criteria for a possible triage of intensive care treatment have not yet been subjected to public debate in France. We will have to tackle this difficult exercise, with the assistance of intensive care professionals, and organize a public debate in which we envisage that some of us may “legitimately” not receive care during a public health disaster. Holding this type of debate would lead to a substantial increase in efforts to ensure that this type of situation does not occur.

**Care and support for non-resuscitated persons**

Given the hypothesis of a shortage of resuscitation resources, a certain number of people with severe respiratory failure will not be able to benefit from assisted ventilation. For most, if not all, this situation will lead to a particularly difficult death unless they benefit from symptomatic therapeutic treatment for dyspnea and anguish.

The persons concerned will be divided into two groups: those admitted to hospital and those at home.

In the hospital, it is possible to postulate that palliative care will be possible and effective. This is nevertheless not certain as the training of staff in palliative care, and in particular the palliative treatment of acute dyspnea in the context of imminent death, is still a real issue[9]. It is one that we must deal with, by providing training of course and also by preparing and distributing palliative kits.

As for home care, the access to “minimum” — but high quality — palliative care is of even greater concern.

It is very probable that due to a lack of anticipation, a high number of deaths will take place in conditions of suffering that could be avoided through specialized care. Will it be possible to coordinate the skills necessary to set up and attentively maintain the palliative measures that are necessary in these circumstances? The techniques will essentially involve...
the intravenous or subcutaneous administration of benzodiazepine compounds or morphinics, accompanied by attentive surveillance and the often subtle adaptation of the administered doses. Will doctors practicing medicine outside of the hospital be available to take on this responsibility? Do we need to provide basic training in these techniques to people from associations or to volunteers? Should we envisage asking families – when they exist – to directly participate in providing care or surveillance that would normally be provided by a professional? Should we not examine region by region the number of expected home deaths based on the epidemiological forecasts and then coordinate palliative care resources? This type of program could have general practitioners receiving advice over the telephone or possibly have special mobile teams making house calls.

Though it would appear impossible to guarantee access to intensive health care or even a bed in a hospital to everyone with a preoccupying health condition during an influenza pandemic, it would nevertheless be our duty to prepare dignified and attentive support meeting best care practices for all those persons made vulnerable by the disease.

References

Ethical Considerations in Preparedness Planning for Pandemic Influenza

Stand on Gurad for thee, A report of the University of Toronto Joint Centre for Bioethics Pandemic Influenza Working Group

Excerpts

A. Introduction

The need for a clearly understood and widely accepted ethics approach to dealing with serious communicable disease outbreaks was underscored during the outbreak of Severe Acute Respiratory Syndrome (SARS) in early 2003. SARS showed the universal vulnerability of humans to communicable diseases, and the need for coordinated and cooperative responses across national borders. It also found that health care systems had generally not prepared themselves to deal with the hard ethical choices that rapidly arose.

Immediately after that outbreak, the JCB produced the report *Ethics and SARS: Learning Lessons from the Toronto Experience*. Since then the JCB has conducted much more detailed research, which is summarized in this paper and will be published in more detail in separate papers.

B. An Ethical Guide for Pandemic Planning

Based on the SARS experience, the JCB Working Group has assembled an ethical guide for planning and decision-making that can be used both in advance of and during an influenza pandemic. This guide is composed of 15 ethical values, of which 10 are substantive values and five are procedural values. They should be seen as a package of interdependent values that are important in any democratic society.

On-line at:
http://www.utoronto.ca/jcb/home/documents/pandemic.pdf
1. Ten substantive values to guide ethical decision-making for a pandemic influenza outbreak

<table>
<thead>
<tr>
<th>SUBSTANTIVE VALUE</th>
<th>DESCRIPTION</th>
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<tbody>
<tr>
<td>INDIVIDUAL LIBERTY</td>
<td>In a public health crisis, restrictions to individual liberty may be necessary to protect the public from serious harm. Restrictions to individual liberty should: - be proportional, necessary, and relevant; - employ the least restrictive means; and - be applied equitably.</td>
</tr>
<tr>
<td>PROTECTION OF THE PUBLIC FROM HARM</td>
<td>To protect the public from harm, health care organizations and public health authorities may be required to take actions that impinge on individual liberty. Decision makers should: - weigh the imperative for compliance; - provide reasons for public health measures to encourage compliance; and - establish mechanisms to review decisions.</td>
</tr>
<tr>
<td>PROPORTIONALITY</td>
<td>Proportionality requires that restrictions to individual liberty and measures taken to protect the public from harm should not exceed what is necessary to address the actual level of risk to or critical needs of the community.</td>
</tr>
<tr>
<td>PRIVACY</td>
<td>Individuals have a right to privacy in health care. In a public health crisis, it may be necessary to override this right to protect the public from serious harm.</td>
</tr>
<tr>
<td>DUTY TO PROVIDE</td>
<td>Inherent to all codes of ethics for health care professionals is the duty to provide care and to respond to suffering. Health care providers will have to weigh demands of their professional roles against other competing obligations to their own health, and to family and friends. Moreover, health care workers will face significant challenges related to resource allocation, scope of practice, professional liability, and workplace conditions.</td>
</tr>
<tr>
<td>RECIPROCITY</td>
<td>Reciprocity requires that society support those who face a disproportionate burden in protecting the public good, and take steps to minimize burdens as much as possible. Measures to protect the public good are likely to impose a disproportionate burden on health care workers, patients, and their families.</td>
</tr>
<tr>
<td>EQUITY</td>
<td>All patients have an equal claim to receive the health care they need under normal conditions. During a pandemic, difficult decisions will need to be made about which health services to maintain and which to defer. Depending on the severity of the health crisis, this could curtail not only elective surgeries, but could also limit the provision of emergency or necessary services.</td>
</tr>
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2. Five procedural values to guide ethical decision-making for a pandemic influenza outbreak

<table>
<thead>
<tr>
<th>PROCEDURAL VALUE</th>
<th>DESCRIPTION</th>
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<tbody>
<tr>
<td>REASONABLE</td>
<td>Decisions should be based on reasons (i.e., evidence, principles, and values) that stakeholders can agree are relevant to meeting health needs in a pandemic influenza crisis. The decisions should be made by people who are credible and accountable.</td>
</tr>
<tr>
<td>OPEN AND TRANSPARENT</td>
<td>The process by which decisions are made must be open to scrutiny, and the basis upon which decisions are made should be publicly accessible.</td>
</tr>
<tr>
<td>INCLUSIVE</td>
<td>Decisions should be made explicitly with stakeholder views in mind, and there should be opportunities to engage stakeholders in the decision-making process.</td>
</tr>
<tr>
<td>RESPONSIVE</td>
<td>There should be opportunities to revisit and revise decisions as new information emerges throughout the crisis. There should be mechanisms to address disputes and complaints.</td>
</tr>
<tr>
<td>ACCOUNTABLE</td>
<td>There should be mechanisms in place to ensure that decision makers are answerable for their actions and inactions. Defence of actions and inactions should be grounded in the 14 other ethical values proposed above.</td>
</tr>
</tbody>
</table>
Recommendations

1. National, provincial/state/territorial, and municipal governments, as well as the health care sector, should ensure that their pandemic plans include an ethical component.

2. National, provincial/state/territorial, and municipal governments, as well as the health care sector, should consider incorporating both substantive and procedural values in the ethical component of their pandemic plans.

C. Four key ethical issues

As a result of analyses of the SARS crisis, the JCB Working Group identified four key ethical issues that are expected to be very important during a pandemic flu outbreak. Below, each of these issues is described in turn to illustrate how this ethical guide can be used. Specific recommendations are included for each issue.

C1. Health workers’ duty to provide care during a communicable disease outbreak

C2. Restricting liberty in the interest of public health by measures such as quarantine

C3. Priority setting, including the allocation of scarce resources, such as vaccines and antiviral medicines

C4. Global governance implications, such as travel advisories
Imagining our role, mission and function during critical periods such as the threat of an influenza pandemic and its arrival is a major ethical challenge. We therefore need to think in terms of duties and responsibilities, notions that we cannot fully explore here, but for which we can offer some broad outlines.

**On the front lines**

In the face of a vital risk such as an influenza pandemic outbreak affecting a large part of the community, the general practitioner, alone in his office, perceives himself as an essential cog in the system and the organization set up to respond to it. Yes, he is alone in his office, in the midst of the population whose health he cares for. But he is also linked to other general practitioners through his on-call duty and the coordination required to ensure the continuity of service through these on-call duties. This gives a collective dimension to the professional group of general practitioners that can only become a reality if each person, in the field, completely fills their role. We will see below how to optimize the ways to fill this role.

In view of the recent critical events that France has had to face, such as the heat wave of 2003, it can be said that French general practitioners completely and spontaneously fulfilled their role with no advance coordination, thanks to their embedded presence among the population, their knowledge of the field, and the quality of their collaboration with the other primary care actors – especially nurses, pharmacists and physiotherapists – by uniting their knowledge and efforts to support the patients that were the weakest and the most at risk. This professional group itself is one of the essential cogs in the care distribution system, working more or less in close collaboration with the hospital emergency wards and also with the local health authorities in each French département (DDASS).

They have distinct responsibilities and tasks situated at different levels which the public authorities must specify and fully support, so that each individual may optimize them. Indeed, each professional has specific knowledge and skills due to his position in the care distribution system. Thus, general practitioners are the only actors who are completely and exclusively in the field, on the front lines (in terms of primary care). This knowledge of the field and of the intervention and organization possibilities is both precious and indispensable, and must be recognized as such. General practitioners and their representatives should therefore be represented in all of the commissions, councils and working groups working on influenza and pandemic influenza, to participate in the design and implementation of the care system.
A vital risk

Of course, the vital risk of each individual would be engaged in the event of an influenza pandemic, and first and foremost that of health care professionals, due to their proximity with their patients who would come to see them at the very start of the outbreak. It was these professionals, for example, who paid the heaviest toll during major pandemics such as the Spanish flu of 1918-19, due to the absence of specific protection equipment. Of course today masks would be made available, but via procedures that have not yet been clearly explained to us. In this situation of vital risk, or at least of morbidity causing unavailability, two equally important points should be highlighted:

- The vital risk is as negative for the community as for the person who incurs it, since any health care professional who is unable to do his job fragilizes the system and its organization;
- In-depth reflection must be carried out concerning the people to treat in priority (first with anti-virals, being fully aware of their limits and the risks of resistance induced by excessive use, and then with vaccination, involving the lead times due to production constraints that we are familiar with).

Yet protecting the population could be started by implementing strict health measures before elaborating more complex systems. These would include individual protection, but also travel restriction measures, population information campaigns on the risks of transmission, etc.

Continuing medical training

Training is an individual and moral obligation. It is linked with each individual’s desire to refresh his knowledge concerning influenza, pandemics, epidemics, individual and collective protection solutions, therapeutics, and the optimization of their use, etc.

One can argue that training is also a collective obligation; an ethical obligation for health care professionals who must make all of their teaching and logistics know-how available to other professional colleagues in order to train them as fast and effectively as possible. The MG Form group has for example developed an evening training program for general practitioners entitled “Informative evenings on avian flu and the risks of pandemic influenza”, and a complementary module intended for their patients (“Messages to the patients of general practitioners”, by Marc Giusti, program coordinator at MG Form).

This program has been in operation since the end of 2005, before the French public authorities set up an official training program for general practitioners via their regional unions (URML), using the available local skills.

Questions that must be addressed

All of these points lead to a certain number of comments or even recommendations.

Intensification of required skills coordination

It appears crucial to equip ourselves with a certain number of resources in order to face a possible pandemic, especially focusing on a more active participation of primary care health professionals in all the local and national bodies during the design of specific care systems.

Refreshing the knowledge of this professional group to render them operational

Although the avian flu has been in the news since 2004, and even 1997 if we include the first cases in Hong Kong and the massive slaughtering of chickens at the time, media excitement has considerably died down, and so probably has doctors’ vigilance, essential in the face of this risk even if it does not currently exist in France. Many general practitioners doubt that a pandemic will occur, doubt its potential seriousness, and only have vague notions regarding antivirals, the risk of resistance to them, their specific use, vaccine production imperatives and stages, etc. This is why it is urgent and important to bring their knowledge up to date.
Establishing strict coordination logistics

If a pandemic breaks out, general practitioners will be among the first affected. This implies strict logistics for the supply of protective means – masks, goggles, medication – but also a new mindset concerning legal and insurance protection: the notions of “occupational illness” or “occupational accident” that have not been recognized to date will have to prevail.

The pandemic risk situation in 2005 emptied French pharmacies of antiviral products and caused a shortage of flu vaccines for the populations at risk. This lack of coordination and regulation can be attributed to the public authorities, who will have to set up stricter conditions for the delivery of certain medications. In this case it would be simple to use the care professionals’ knowledge of the field with a set of epidemiological data adapted to the situation.

Unless we believe that the market should rule, we must try to draw some lessons from the Chikungunya epidemic on Reunion Island concerning the delay in informing professionals, the insufficient use of general practitioners and their skills, the lack of stock in pharmacies, and the absence of home care coordination, so essential in these situations.

Implementation of exceptional measures

A possible pandemic outbreak will not stop life from continuing as usual: not only will there be widespread flu, but patients with high blood pressure, diabetes and heart problems will continue to visit their doctor and require care. This already heavy workload, intensified by a pandemic, will require efficient operational organization and the implementation of exceptional assistance measures, i.e. bringing back retired colleagues, making medical students available to overworked general practitioners, etc. From this standpoint the government’s plan concerning assistance to professionals appears fairly weak at this time.

Creation of an outpatient care service

In the event of a pandemic, priority is given to calls arriving at the national emergency call number (15). Yet everyone knows that this call center is rapidly overwhelmed…. Moreover this system, which therefore does not appear the most operational, considerably marginalizes the general practitioner since he becomes a simple executor of the missions entrusted to him by the 15 staff, rather than a true regulator and organizer in the field. Consequently it appears necessary to set up an outpatient care service that should first be experimented with.

These important points should be taken into account in order to better tap the resources represented by the 50,000 French general practitioners, since they will be essential actors in combating a pandemic that all experts agree is inevitable. If it fortunately does not occur, this situation of pandemic risk forces us to give deep thought to our health care system, its inequalities, its insufficient recognition of certain skills, and the way in which we distribute care.

This reflection, conducted in all health care circles, should logically result in better coordination and communication and an optimization of the coherence of our country’s health care system.

References

MG Form training program: mgform@medsyn.fr
A considerable amount of forward planning has been done to prepare for an influenza pandemic. This planning focuses on managing the disease and the curable patients, and even includes projects to reorganize the economic and social system. It also addresses the issue of managing a large number of corpses to limit their health and social impacts. Yet it does not seem to take into account issues linked to caring for those patients who, ill but considered incurable, will “not yet” be corpses.

This is a classic shortcoming of modern medicine, observed for many years for example in the fight against cancer[1]: ignoring those who can no longer be an object of science yet nevertheless remain individuals and as such have rights, even if they are “quasi-dead”. This period of agony and dying is considered so devoid of meaning that some even propose to shorten it. On the contrary, one of the fundamental points in the value system of the palliative care movement is to recall that medical “care” includes “taking care of” even those who cannot be cured[2].

We must therefore recognize that, in line with current sociological trends, the fate of suffering patients who are going to die does not seem to have a place in the frenetic planning surrounding a hypothetical pandemic. Yet in the envisaged disaster scenarios, is it not legitimate to pay attention to the distress of these patients? According to the clinical picture of avian flu, they will suffer from extremely uncomfortable symptoms: asphyxiating dyspnea, thoracic and/or abdominal pain, hemorrhagic diarrhea, etc. The probable shortage of medical and technical resources and also of available time leads us to imagine unacceptable conditions of agony, combining pain with suffering.

Due to isolation requirements, no comforting presence can be expected from family and friends, and for the same reasons the presence of volunteers is also completely unimaginable. Health care professionals will already be completely overwhelmed by the demands of those who require their curative care. In a utilitarian position, they will not have time for these incurable patients who will thus remain alone in the face of death. It is easy to imagine the ethical tensions generated by these intolerable situations for distraught health care professionals, and the
obvious temptation to do something to "get it over with". This is no fanciful hypothesis. As was recently recounted in an article in the French newspaper *Le Monde*[^3], a case concerning multiple euthanasia is presently causing intense debate in Louisiana. In August 2005, the Memorial Medical Center was isolated by flooding after the passage of Hurricane Katrina. The power was out in the 317-bed institution, and the inside temperature exceeded 38°C. A doctor and two nurses are accused of having provoked the death of several elderly patients. Arguing that these patients probably would not survive, the doctor and nurses chose to "relieve their suffering". However the state of Louisiana represented by its attorney general argues that the patients, victims of the "compassion" of the 3 health care professionals, could possibly have survived this disaster, and that therefore the decision made to euthanize them is equivalent to murder. Therefore it is probably not futile to initiate reflection as to what should be proposed to prevent health care professionals from finding themselves in a similar aporetic situation in the event of an H5N1 influenza pandemic. ■

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The major ethical “event” that public organizations must confront during exceptional crises is the loss of confidence in the decision-making authorities, which then challenges the legitimacy of these authorities and makes their decisions inapplicable.

The major ethical “event” that public organizations must confront during exceptional crises is the loss of confidence in the decision-making authorities, which then challenges the legitimacy of these authorities and makes their decisions inapplicable.

Therefore a company must deserve the confidence of its members, both management and personnel, in order to give rise to this position, to prepare the company to assume its ethics in a crisis, and to ensure the credibility and thereby the effectiveness of the decisions of a prevention and crisis management plan.
It must do this with three objectives:

1. Confidence in the company’s human, technical and economic ability to carry out the specific objectives assigned to it in a pandemic crisis: as an industrial actor, to ensure the continuity of energy supply and the security of the installations in a degraded context; as an employer, to minimize the social and health impacts of the pandemic on the Group’s employees exposed in their professional lives (and indirectly their families in the context of a pandemic); as an economic actor, to safeguard the operation of an organization essential to daily life.

The quality of the company’s crisis preparedness (reliability of the prevention and management plan: dependability, coherence, resources committed, decision level, control) is therefore one of the main conditions for confidence.

2. Confidence in the legitimacy of the decisions planned or made in view of the risks or damage that they could cause to employees and their families, and also to any potential third party victim. And on the contrary, confidence in the illegitimacy of any type of discrimination or selection that would not be justified by the objectives and ethical conditions of the company’s mission. There is no such thing as a degraded mode for company ethics during a crisis and it is the values of respect for people and the environment, of solidarity and integrity that must be used to evaluate the recommended measures and the decisions to be made.

3. Confidence in the message that the organization conveys about itself and also in the statements made by its “decision-makers”: clarity of motivations for decisions made or planned, and accuracy, sincerity and honesty in the information shared concerning the degraded conditions of the company’s activity and its performance in or out of the plan’s framework.

**PRINCIPLES OF GOVERNANCE**

For the above reasons, there is a need to formulate and implement three series of principles to explain this ethical position in the framework of pandemic preparedness:

- A principle of effectiveness which is also a principle of reality: it firstly consists in putting our company performance at the service of our mission to ensure the continuity of energy supply in a degraded context, the safety of our facilities, and the safety and health of our employees. Effectiveness in a crisis is not only judged by the capacity to mobilize intellectual and material resources, as represented by the allocation plan and by the effective use of the Group’s operational components to prepare for a pandemic crisis. One must also plan for the fact that standard organization and operating modes will no longer be appropriate (systemic crisis), by encouraging an ability to anticipate without any taboos (strength of quick thinking) and a capacity to respond and to share information that takes into account the unpredictable short circuits, and the suspension of power and information links (crisis management cells, decentralization of powers, etc.).

At the same time, this crisis performance must not neglect the constraints of its environment. On one hand, the legal, national or international framework that may be experiencing exceptional measures, but in particular, the more precise and more directly constraining framework of the government’s pandemic preparedness plan, or for the subsidiaries, their government’s plans or any international recommendations. This subsidiarity to an external framework should not lead the company beyond or below its own objectives. Beyond, it is diverted from its objectives towards a general mission to combat the pandemic that it cannot and must not take on; below, the company itself goes into degraded mode and jeopardizes its longevity.

- A principle of solidarity that is also one of equity: solidarity is firstly that which is required by the crisis and which mobilizes the company to act in the general public interest. This principle also requires cooperation, in particular in situations entailing a health risk or distress, and mutual assistance with other public actors or operators, but also with individuals in the community living through the same situation. Beyond cooperation (sticking together!), the inspiration of “solidarity” in measures and actions is indispensable, since it supports respect for others, respect for survival conditions (environment) and a respect for the essential social rules (integrity, honesty). However, even in a pandemic crisis (except for grave and immediate danger), this solidarity can not be indefinitely or blindly extended, in particular in the name of equal treatment: its borders are drawn by the company’s economic and social objectives that it strives to reach through its performance and that define its priorities. Essential equity arbitrations must therefore be made at each stage of the crisis, for
example to select the essential people to accomplish the mission, to allocate resources (including health protection) and to provide assistance.

A principle of transparency that is also a principle of governance: losing confidence starts with doubting the other’s word, if the other has even expressed himself. The wait for authorized information is not specific to a crisis, but this wait during a health threat and in conditions of ambient disorder favors all types of degraded information: rumors, confusion, projections of fear or irrational hope, but also censure, propaganda or brainwashing. Due to this, the crisis disqualifies all statements and information. For a decision to be conveyed, believed and applied, the information that it provides about its own raison d’être and objectives must be credible, and thus the plan itself and its preparation must have given authenticity to the decisions and information communicated to the actors of the plan or their representatives in the company, satisfying the expectations raised by a vital health risk and an exceptional public threat. Hence there is a strong obligation for transparency in a pandemic preparedness plan, which goes beyond just sharing the information required for the decision makers. The objective is to demonstrate the effectiveness (anticipatory or responsive performance) and legitimacy (solidarity, equity) of the collective approach in the elaboration and decision-making. A pandemic crisis will therefore generate a new model of governance, more transparent, more participatory and... more ethical.

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Call for articles

Pandémics® is available on the Internet in French and English at: www.espace-ethique.org/fr/grippe.php Click on the PDF link: Pandemics.

The editorial team at Pandémics® would be happy to receive proposals for original articles devoted to the ethical and societal issues raised by the possibility of an influenza pandemic. Articles chosen by the reading committee will be published in French and English. The texts must not exceed 15,000 words, must be written either in French or in English, and must be sent by E-mail with full contact information concerning their authors to: journal.pandemics@sls.aphp.fr.

Contact editorial team:

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A possible influenza pandemic and its serious consequences lead us to question our society’s ability to respond with solidarity.

People working in the voluntary sector naturally appear to be priority actors in this crisis, whose management is a collective responsibility. Indeed, they can be mobilized in the event of need, can offer strong personal commitment, and can very often adapt and innovate in the face of unexpected situations.

According to the French statistics institution INSEE, 13 million French volunteers currently give some of their free time to society, and one third do so regularly, in over a million associations in every imaginable sector. Only 15% of these associations work in the social, health and charity sector. Moreover, the arrival of an influenza pandemic would undoubtedly require calling upon volunteers beyond the health sector, i.e. from the sports, cultural, recreational and educational sectors, as well as from human rights defense associations.

There are three major arguments in favor of including the voluntary sector in a system to combat an influenza pandemic.

The first, both qualitative and quantitative, is to be able to tap the experience that these associations already have in managing difficult situations (especially in the health and social sectors where the presence of suffering, illness and poverty require the appropriate responses). Moreover, certain associations demonstrated their ability to work in grassroots networks during the French heat wave in 2003. The sheer number of their volunteers is also a considerable quantitative asset.

Nevertheless, their mobilization in times of crisis remains debatable and depends on multiple factors linked to the diversity of the voluntary sector, the degree of commitment of the volunteers

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**At the core of mediation processes, and as creators of social ties, volunteers appear ideal to ensure the function of global patient care continuity.**
to their association, and the information available to the sector. In addition, we must examine a major unknown variable concerning mobilization: does the fact that people become volunteers necessarily mean that they are ready to put their lives on the line for others, or that they ought to?

The second argument is that of access to the information network set up by the voluntary sector and considerably enlarged in recent years, notably on the Internet. These associations are capable of widespread information dissemination reaching beyond their own members, and calling upon structures such as France Bénévolat (France Volunteers) and Espace Bénévolat could amplify the circulation of information and instructions inherent to the management of such a crisis.

Finally, thanks to the diversity of the scope of its applications, the voluntary sector should naturally be associated with a system to combat a pandemic, since it is already dealing with the essential questions that will be raised.

At the core of mediation processes, and as creators of social ties, volunteers appear ideal to ensure the function of global patient care continuity. Associations have a role to play in defending patients’ rights that might be threatened by widespread panic (for example the rights of people in quarantine). They can provide support to patients and their families at home, for example by developing programs to respond to daily needs (nursing, companionship, errands, etc.). Their presence will also be necessary in homes after the pandemic, when it will be necessary to restore a social life that was interrupted or even destroyed. Associations already working in hospitals will also be asked to greet and reassure families and friends and thus contribute to attenuating the inevitable tensions.

The French associations whose vocation is to support patients and who have expressed themselves on this point have immediately confirmed their desire to provide support to patients infected by avian flu. But there is apparently no consensus today on this position among all the associations. Too many questions remain unanswered: how can one be useful in the context of a quarantine, i.e. almost total isolation? Is it wise to call upon volunteers who may then become vectors of the disease?

Mobilization methods

The voluntary sector can play a determining role, including in the field of training.

Some associations have been dispensing high quality training for many years and are able to extend this to a wider public. Others, weak in this area, will have to evolve if they wish to play a decisive role during the crisis. Volunteers must be prepared, supported and assisted. For example, they must be trained to deal with the abandonment of the most helpless patients – the elderly, disabled or socially vulnerable – by health care personnel or even family and friends. One cannot ignore the fact that asocial and deviant behavior inevitably arises during disasters of this magnitude.

As for the public authorities, we must rightfully ask ourselves what coordination and training resources will be made available to reinforce the effectiveness of the voluntary sector, so highly diversified and at times poorly organized. What health protection will be proposed to the volunteers exposed to contagion? Will it be identical to that offered to health care professionals? These concrete questions must clearly be raised.

It would seem at first sight that there is a consensus concerning the need to mobilize the voluntary sector in the event of an influenza pandemic, but can this affirmation resist the complexity of the questions it raises?

We do not yet have the means to measure the probable extent of the voluntary sector’s involvement in the system to combat avian flu, since the data in terms of figures, task definition and means of intervention is still too vague and unreliable. The first surveys of voluntary sector leaders on this question were edifying,
and revealed that most of them felt that the idea of an influenza pandemic in the near future was directly inspired by a science fiction scenario... How can we thus mobilize people around something that they feel is improbable and that we ourselves prefer to relegate to the very depths of our consciousness?

**The Pharmaceutical Industry Faced with the Risk of Pandemic Influenza**

The initial debates concerning a pandemic influenza risk for our societies immediately brought to the fore the role of the pharmaceutical industry in the fight against and prevention of disease. As soon as the threat became real and the public authorities made their first statements, all eyes were focused on this private actor. Would it have the means of preventing another new health disaster? Would it have effective therapeutic solutions, in time and in sufficient number? The media coverage of the promises of the vaccine or the antivirals reached hereto-unknown peaks\(^{(1)}\).

This rediscovery by public opinion of “drug entrepreneurs” occurred with the usual associated suspicion. The economic stakes linked to finding therapeutic solutions fanned the rumors and, once again, raised the fundamental paradox of a medication: a public health commodity developed and produced by a private actor. Among the questions posed to the pharmaceutical industry by the influenza pandemic risk, there are at least two that dominate due to their specificity.

**Ensuring Public Health Priorities**

The first concerns the fundamental mission of this industry that, beyond the treatments that it could propose...
to fight influenza, already allows hundreds of thousands of our fellow citizens to combat different illnesses or simply to go on living. It would be very difficult to accept that a health crisis, even a major one, could jeopardize the principle of solidarity towards the most vulnerable, on which our societies have built the strength and greatness of “living together”. Yet, during a crisis, the pharmaceutical industry’s mission would be weakened, in particular due to the vulnerability of its own workforce. From this viewpoint, how should this free market actor, among all the industrial sectors concerned, prepare itself for the risk that threatens its operation?

The question goes far beyond the simple economic considerations of business continuity and the implementation, in all industrial sectors, of a special degraded business plan. Regardless of what happens, this industry must be capable of producing and dispensing the medications without which many sick people would rapidly be condemned. It appears difficult to accept that a hierarchy be established that would at the outset exclude some patients from the hope of being cured or simply surviving. There is a popular old saying that criticizes the absurdity of having to choose “between the plague or cholera”. In a more contemporary way, giving preference to influenza over cancer appears to be an extreme that no ethical argument could justify.

To maintain the availability of treatments discreetly designated as “public health priorities”, must this industrial sector be the object of exceptional measures? In that case, what governance principles must it adopt in the case of a major health crisis when the national authorities are considering applying measures that limit individual liberties? Here the responsibility of a private company intersects with that of the community. Pharmaceutical companies are most certainly preparing themselves for this possibility, but the decisions that they may have to make will set them apart from their counterparts in other sectors or even from their public and private partners. These decisions inevitably raise questions concerning the concept of equality in a crisis situation. To this end, the obligation of forward planning brings up another obligation: that of dialogue and pedagogy. All of the stakeholders involved – health authorities, health and industrial professionals – must work together to explain and remain as transparent as possible regarding the choices made.

**It would very difficult to accept that a health crisis, even a major one, could jeopardize the principle of solidarity towards the most vulnerable, on which our societies have built the strength and greatness of “living together”**.

**Not jeopardizing the future...**

We must also consider the exact nature of the risk incurred by a pharmaceutical company due to an influenza pandemic, since an essential part of the company’s business is forward facing and constitutes a potential to improve the health of future generations. In other words, how can the management of a health crisis, according to ethical priorities of immediacy, endanger or even jeopardize the development of future therapeutic solutions, which during the crisis may appear secondary?

In order to provide a new medication to those in need, we require an average of 7 years of clinical development, numerous studies in strict and scientifically valid conditions, hospital beds and a significant amount of time from the health care teams that implement and follow-up these tests. The partnership between the private investor sponsoring the research, the university researchers and the health care centers is decisive. What would happen to the active substances and samples in the context of a shortage of hospital beds, overworked health care teams and reduced patient mobility? It would be advisable that the priorities set for health care facilities and the medical community do not drastically impinge on the investments in place to develop future therapeutic solutions. Doing so would boil down to establishing a moratorium of sorts on therapeutic research, against the impatient expectations of thousands of citizens. Above and beyond the considerable economic stakes, it is the future of our health that may be threatened by arbitrations of priorities.

Must precise directives be decreed to continue to ensure, under certain conditions, the continuity of clinical development, at least for the most serious pathologies? Is it scientifically relevant to envisage periods where programs would be “on hold” and to take them into account in clinical research protocols? It seems that we lack policy and forward thinking on this topic... Yet the management of this situation is even more complex given that the current international nature of research work leads to new coordination constraints:
decisions made by any one country will have consequences on the validity of the results on a global level.

All of these questions must obviously be debated in professional organizations and with the different health authorities. It is nevertheless true that the collective management of a pandemic risk challenges certain answers that leave a lot of maneuvering room to individual and national strategies. Now more than ever, the capacity for dialogue, common reflection and coordination between the different health stakeholders seems primordial. The principle of responsibility, which must be exercised at all levels, must take into account the often different nature of the stakes for each actor... Seeking convergences is the only way to reach fair and beneficial decisions.

Ethics & pandemic influenza conferences

Within the framework of the national policy for preventing and controlling Pandemic Influenza, the Paris-Sud 11 Ethics Research Department and the Espace éthique of the Assistance Publique/Hôpitaux de Paris propose 4 theme-based conferences focusing on the ethical and social stakes of a possible pandemic.

I – Ethical stakes, democratic challenges
Friday 13 October 2006
II – Ethical stakes, access to care and treatment
26 January 2007
III – Ethical stakes, rights and duties of professionals
22 June 2007
IV – Ethical stakes, mobilising society
21 September 2007

Informations :
http://www.espace-ethique.org/fr/grippe.php

Reference

[i] The press coverage of oseltamivir (Tamiflu®) to date has been greater than that generated by the invention of the first treatments for AIDS.
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- **Psychological representations and impacts of a pandemic**  
  Odile Bourguignon

- **Fear and contagion**  
  Nicola Grignoli

- **Promoting ethical responsibility in communication about pandemic influenza**  
  Jean-François Ternay
In any ethical reflection regarding the threat of a pandemic, we must take into account the psychological impact of such an event. Otherwise the values that we wish to promote risk being perceived as meaningless.

Whether natural, caused by man or resulting from his lack of foresight, the collective disasters of the past can teach us many lessons.

**FROM THREAT TO SOLIDARITY**

The arrival of a pandemic can create a traumatism leading to sideration of thought and paralyzed reflection: the incredulous individual denies reality and does not prepare himself for danger, which when it arrives, induces him to rebel, panic or abandon himself to fate. Proximity with death can therefore cause reactions of active defense, but also anxious reactions of different types (prostration, abandonment, bereavement, etc.) and often an immense feeling of powerlessness in the face of the inevitable.

When one third of the population of Europe died of the plague in the 14th century, the church walls were covered with macabre paintings of dancers in which everyone, regardless of rank, power or merit, joined the cohort of the ill, and death seemed to choose people at random.

Panic can arise when individuals feel brutally abandoned to their own devices without help: they then react according to the circumstances. If nothing has been planned or organized, it is then individual survival and the protection of one's own property that become a priority at all costs, with only a few rare exceptions. One then observes a regression to purely instinctive behaviors, to the detriment of moral and social values, such as in wartime when moral norms and values are suspended even at the level of the States and when individual behavior can range from heroism and altruism to cruelty and murder.

According to Freud, this panic, similar to that observed when a leader dies, brutally interrupts the identifying ties that individuals had in common, leading to total chaos.

But the threat of a pandemic, and of course its arrival, can also enter into resonance on the individual or collective level with a certain taste for, attraction to or fascination with death.

There are plenty of models to help us imagine what type of human behavior could occur in the event of a pandemic. At a conference a few years ago, the pediatrician Alexandre Minkowski showed some slides concerning the fate of children during wars, and in particular the Vietnam war. One of the slides...
Serious events always encourage the expression of extremes.

portrayed a class of schoolchildren 3 to 5 years old surrounding their teacher. Since the village was bombed 10 to 15 times a day by the American army, she had set up small groups of 4 to 5 children placed under the responsibility of one child in each group, and had taught them basic first aid. As soon as the alarm went off, she stopped teaching, and each child picked up his first aid kit and went with his group to the underground shelter previously built by the villagers. Once the bombing was over, each group came back up and school resumed as usual.

What lessons can be learned?

The prevention of a pandemic starts with its precise identification by the competent authority. To respond, we need to rise above the current generalized confusion concerning who does what, and understand what type of coordination exists between general and local measures: where should one address oneself? To the hospital? The town hall? The prefecture? The Ministry of Health? The local health authorities (DDAS)?

Prevention requires the existence and knowledge of the organization of governmental and non-governmental networks, private associations and health care professionals, as well as of the non-professionals who want to make themselves useful.

It is possible for most people, provided that a well designed, rational organization has been set up, to accept constraints and limitations to their usual freedom in order to establish a certain equality in the access to care. This is a necessary but insufficient condition to limit individualistic and anarchistic behaviors. Serious events always encourage the expression of extremes. Thus, faced with purely regressive behaviors, individuals, up until now completely inconspicuous, can suddenly demonstrate exceptional generosity and selflessness.

But we must also be able to mobilize the majority. It therefore appears impossible to recommend the ethical values of respect for others, equality and solidarity without simultaneously requiring that political and health officials plan a response to the pandemic, though we already know the limits to these plans: for example the organization of additional networks on the local level can also create or reinforce the social ties so essential in the event of a collective disaster.

In the France of 2006, where it seems so difficult to tolerate differences and disabilities of all kinds and everyone's eyes are riveted on security, the ethical value that would perhaps find the strongest support would be solidarity: equality, even if it can be a goal, has been too negated, and liberty remains contingent, whereas solidarity prepares the future.

An influenza pandemic therefore invites us to think globally about the appropriate response to collective disasters (including nuclear catastrophes or terrorism).

Although some people are more socially, psychologically or biologically vulnerable than others, a pandemic can affect every one of us. It is indeed difficult to concretely mobilize people before a disaster actually occurs, but what did the tsunami of December 2006 teach us? That each person is able to respond when they are personally involved. This is one of the powerful levers of solidarity.
Nature has always challenged us with periodic devastating cataclysms, able to modify the planet’s equilibrium and practically annihilate all forms of life. Recent history has shown that the power of technology is a double-edged sword that also endangers us, cutting away at the roots of our ideal of progress. Among these catastrophic natural and technological threats, the transmission to human beings of viruses responsible for epizooties is a frightening new risk. From meteorites to weapons of mass destruction, from the greenhouse gas effect to pandemic influenza, the tsunami of risk factors overwhelms us with feelings of helplessness and insecurity. Threatened on all fronts, it seems fortuitous that our species continues to proliferate, as if under the effect of crushing and inexplicable feelings of guilt we were just waiting for a disaster to happen in this best of worlds.

Catastrophes and mass panic

Of course the notion of risk is not just a fantasy, and danger is sometimes real. Today we wish to prepare for the possibility of a pandemic caused by the transmission to and between human beings of the avian influenza virus A-H5N1. We cannot help remembering the Spanish flu of 1918, probably of avian origin, that killed 20 to 50 million people. The precautionary principle is therefore justified and necessary. Here are the facts: 244 people have been contaminated since 2003, and the mortality rate exceeds 50%[1]. Transmission from animals to humans does not appear easy, nor likely to occur through the ingestion of infected animals. No proof of contamination between humans has yet been established. On the contrary, this type of transmission is apparently difficult due to the anatomical differences between humans and avian respiratory systems[2]. The present pandemic alert situation is classified by the WHO at level 3 (“no, or very limited, transmission from human to human”) on a value scale of six[3]. Even if the risk continues to be low, the uncertainty remains. After a phase of genuine alarmism[4], we are now witnessing a phenomenon of habituation and released tension regarding a threat that no longer seems imminent. Contradictory information and widespread doubt actually lead to a lack of cohesion in the perception of reality and a resulting loss of confidence in institutions. What is the impact of the “certainly impossible”[5] on public opinion? The study of collective psychology[6] has taught us that although individuals can be influenced by the same passions and affective laws, their way of thinking in a group conforms to the lowest common denominator. The masses can also show exaggerated mood exaltation and excessive sensitivity to the messages that can provoke these moods. They suffer from a special aptitude to sentimental contagion and imitation, most often triggered by an outside element or agitator. Once a very emotional idea is suggested, it spreads
like a virus and maintains itself, waiting for new orders from the leader or until exhaustion sets in due to a lack of excitation. In our case, the media act as channels of suggestion for theagitators and can concretely influence pandemic preparation through enlightened collaboration with political and health leaders. The interaction between power and information cannot be improvised in this case, but must envisage the pandemic diffusion process as a twofold contagion, both viral and emotional.

**A SACRIFICIAL MOTIVE**

The information disseminated about this pandemic risk initially generated a feeling of collective fear. As a true wake-up call demanding action, this fear concretely expressed itself through preventive slaughtering and confinement measures, which strongly impressed the public and created a sensation of “uncanniness”. It is this first reaction that we would like to analyze from the anthropological standpoint. The massive slaughtering of apparently healthy animals can indeed be compared to Native American offering rituals in the Pacific Northwest, studied by anthropologists under the term *potlatch*. These abundant offerings, shared and sometimes immediately destroyed during these festive ceremonies, represent – in the strongest sense – the social status of the ritual actors, and serve as a pretext for social encounter and reciprocity, or what Marcel Mauss calls the “gift and counter-gift”. Moreover, in its most extreme expression, this ritual demonstrates economic power and goes beyond control and utilitarian law. Waste is then part of the profound significance of the ceremony, which can be interpreted as an ode to a higher principle through the ostentatious rejection of utilitarianism and materiality. Yet for anyone exterior to this ritual, or for whom this “thing” does not correspond as such to a ritual, the absence of apparent meaning suggests the need for a compensation or reestablishment of the logical order of things. Thus, in the particular case of bird slaughtering, proposals along these lines were made, for example to recycle the meat as food for the underprivileged. Specific methods were also recommended to offer a “humane death” to these living beings killed for control and prevention purposes. Yet these collective simultaneous sacrifices of millions of animals, usually euthanized with gas (hypoxia) and whose carcasses were burned for hygienic purposes, **continue to raise questions:**

- Are there symbolic reasons for this animal holocaust? - Can it be interpreted as an unconscious secular sacrifice?

As with the plague in medieval Europe, a pandemic can be interpreted as a divine scourge, a punishment of guilt – the recourse to the supernatural and the magical often being the ultimate way to deal with lack of meaning. Such a conception of disaster makes it possible to imagine another explanation for this animal slaughtering as a measure taken to respond to the threat of human annihilation. Animal sacrifice is mankind’s traditional way of communicating with the transcendental. The sacrificial rite is considered a necessary offering to re-balance our debt to the divine – a sentence to pay for our faults – or to satisfy a request. But in our case, what is the fault? In their flight, have human beings flown too close to the sun?

**BEYOND THE HEURISTICS OF FEAR**

The preventive precautionary measures taken to manage the pandemic risk, responding to a desire for safety provoked by deep-rooted fears, mix with and adapt to latent contents. Indeed, it is easy to observe that the response of the masses to danger is inspired by emotional rather than rational motives. These situations of anxiety and panic, intermingled with complex contents, are also easily exploited by all kinds of powers, notably economic, political and religious. The Ethics Reflection Platform on Pandemic Influenza develops its reflections in the wake of human and citizens’ rights, and dares to imagine the unimaginable. Its approach seems justified in view of the likelihood that a planetary pandemic would deeply disrupt the cohesion factors maintaining law and order and social equilibrium in our civilizations. The social contract underlying the policies of our democratic societies is based on reducing individual liberties to allow the State to protect the population. A genuine viral contagion exposing the entire population would give rise to virtual equality recalling...
our original natural state, especially since the contamination by animals would impose a sort of ontological equality confirming Darwin’s narcissistic wound. This would provide a dramatic opportunity to verify the appropriation of community principles by individuals left to their own devices and facing the fundamental need for survival. Two collective reactions are then possible: individualistic disintegration or reinforced solidarity.

Simply referring to these catastrophic scenarios makes the earth shake under our feet, and in this case, fear can obviously reveal ethical truths. Yet we feel that the opportunity to examine pandemic risk without becoming obsessed by the contagion of fear is our responsibility.

References


[8] The WHO avian flu conference in November 2005 in Geneva reported that 150 million birds in the world had undergone precautionary slaughtering over two years. WHO website, joint article by the WHO/FAO/OIE/World Bank, 4 November 2005.

[9] Freud’s expression translated from the German Das unheimliche, meaning the feeling triggered by the unexpected emergence of the identical through repetition. This is most frequently illustrated by superstition and fiction: Freud S., L’inquiétante étrangeté et autres textes (The Uncanny and other texts), Paris, Gallimard, 2001.


[12] We recall here that this word comes from holos and kaiein, which respectively mean in Greek “all” and “burn”.

Distinguishing between information and propaganda

An ethical approach to communication addresses the content, the conditions under which information is produced, the way the communication is handled and the information circulated and received.

Where avian flu is concerned, it is about adopting an approach to ensure that target receivers understand not only what is said about avian flu, but also the motives behind what is said, the origin of the viewpoint and the underlying intention. It is also about giving the possibility to different publics to perceive forms of discourse, to identify formal and seductive aspects as being rhetorical so that they can then differentiate between information and propaganda.

It is a question of applying a transparent approach that aims to give people the means of exercising their free will and acting on what is said with full knowledge of the facts.

For example, when it comes to avian flu, it is not always easy to know what makes the discourse of a scientist, an expert or a journalist legitimate. Are scientists speaking on their own behalf, on behalf of a ministry or on behalf of a university? Are experts commissioned by a non-governmental organisation, a government, a vaccine manufacturer or a group of poultry farmers? Are journalists adopting an independent stance on what they say?

There are hundreds of blogs, forums and news groups devoted to a possible pandemic. Many of these do not have an explicit signature or hide behind pseudonyms, which makes it difficult to appropriate the information they contain, and even leads to dangerous rumours.

There can be no appropriation of information without discussion. And without appropriation there can be no actions possible other than those that are psychologically or physically imposed.

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as saving as many people as possible, the agro-food industry, a government policy or selling Tamiflu® and protective masks as is the case of many Internet sites.

**The necessary debate**

Furthermore, public appropriation of information is only possible if a certain critical distance can be maintained, beyond a simply emotional buy-in. The natural authority of governments and international bodies, but also of scientists, doctors and journalists, is unconditionally adhered to by some while provoking rebellion in others. Such attachment and emotional response is not conducive to free thought and must be prevented. The same applies to the use of fear to impose a viewpoint by frightening people and triggering their emotions thereby blocking any form of communication. The film “Fatal Contact”[2] and more generally the shock caused by the words and photos used in the pandemic alerts circulated by the media are good examples of this.

Still, it is not always easy for spokespersons to adapt to different publics by allowing the motives behind what they say, the constraints binding them and their recipes for seduction to become apparent. This is why they must allow others the possibility of doing so. It is through debates on avian flu that we shall be able to shed some clarity on each person’s motivations and the motives behind their arguments. Governments especially must encourage controversial discussions rather than guarding against them. The very least they can do is allow counter-authorities to open a debate about what is said.

There can be no appropriation of information without discussion. And without appropriation there can be no actions possible other than those that are psychologically or physically imposed.

An ethical approach to communication is thus one that invites us to be transparent about content and positions, notably with respect to the most vulnerable targets that often get lost in the complex labyrinth of information and stakes. It is an approach that invites us to debate what is said about avian flu.

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**References**

[1] Blog: abbreviation for Weblog, an online individual diary which, unlike the website, is constantly updated.

# International Issues

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- **Africa and the notion of an influenza pandemic: why act, how, and for whom?**
  Charles Becker
Contemporary historians have examined social responses to disease. Focusing mainly on epidemics, they have highlighted the importance of the representations of the disease, which are determined by knowledge of the disease and imposed behaviors mainly defined by those who possessed knowledge that was sometimes empirical or uncertain but nevertheless recognized as a reference in the action against the epidemic disease. In the past, these conceptions often led to social practices expressing “fear” and terror in the face of epidemics. They had an enormous influence on the reactions of societies that, in the past, once they had identified the “scourges”, accepted and even recommended rejection, stigmatization and abandonment of the sick, which only a few “saints” refused to accept. Nevertheless, historians have observed significant evolutions linked to the decline of endemic and epidemic diseases and to the implementation of new forms of solidarity, such as national health insurance in Northern societies.

For the past two decades, historical research—especially in English—on health in countries formerly under colonial domination has shed new light on the history of health in contexts where the mortality due to epidemics was simply an addition to the very heavy toll paid to the more ordinary endemic diseases that were neglected for many years[1]. This research encourages us to try to understand the social rationales at work when faced with an array of familiar and more or less well identified diseases, also noting the importance of knowledge of the disease. It has above all shown how the definition and application of health measures—based on medical knowledge—also participated in a broader system of colonial domination that imposed its political, economic, cultural and social supremacy on local societies.

**Social Management of Disease**

Africa, considered in the 19th century as the “dark continent” and the “white man’s tomb”, was for decades renowned and feared for its devastating endemic and epidemic diseases. Foreign health authorities defined more authoritative health policies there than elsewhere, often reinforcing inequality through the unequal availability of scientific progress and the concentration of infrastructures in urban centers[2].

There has been considerable historical research on epidemics in Africa, especially inspired by the emergence of AIDS in Africa where reactions of rejection were massively amplified, in a situation in which medicine was not available until very recently[3]. The work of the historian Myron Echenberg who has studied historical epidemics is relevant here. Myron Echenberg started researching Spanish influenza in Africa, in particular in Senegal. He was surprised...
to find very few documents and to discover that this pandemic, as deadly in Africa as anywhere else, left practically no trace, either in African societies or in the accounts of European doctors and in the archives. However, there are considerable European medical and archivist records on the bubonic plague[4] and strong traces of this epidemic in the local historical memory. The contrast between the social treatment of the two epidemics, of which one caused many more deaths than the other, is striking. The plague, much better known and feared by doctors and Europeans, was managed under the control of the medical authorities who imposed extremely strict medical measures, considered in African memory as coercive and non-respectful of human rights[5]: the doctors recommended and tried to impose – based on unfounded scientific beliefs – spatial segregation for health reasons, creating a “native” neighborhood, the “Medina”, where the black population was to be quarantined[6].

History demands the re-examination of certain Western biomedical attempts which, although they were undoubtedly successful in preventing (with vaccines that were distributed to both Africans and Europeans as soon as they were ready) and treating certain diseases, often imposed Western motives and used the colonies as a giant experimental laboratory[7]. Moreover, history reveals how the social management of diseases – and especially epidemics – was essentially the action of a colonial power that controlled prevention, the implementation of health measures, and the organization of the health care system. This also underscores the need to take a new look at the way African societies experienced, interpreted and treated these diseases, and how they accepted, rejected or compromised with the strategies put in place by colonial administrators and doctors.

Historians studying health questions in colonized countries, especially in Africa, have emphasized that epidemic episodes were powerful indicators of social inequalities and did not affect the different social groups in the same way, which is still true today when you consider the progression of the deadly AIDS epidemic in Africa[8]. Inequality in the face of health problems and death becomes crystal clear in times of crisis; for most epidemic diseases, the context also includes economic factors such as rapid urban growth, migration for employment, urban poverty, the abandonment of rural areas, and the shortcomings of the health care system, which all encourage inequality[9].

These historical facts are useful to remember when considering the case of influenza, or rather the forms of influenza that could affect African people and societies in the event of a pandemic. We simply propose some avenues of reflection based on an observation of the messages concerning pandemic influenza and the spread of avian flu communicated to a continent already struggling to eradicate other ills and diseases.

**Threats and reality of influenza in Africa**

The identification of this disease has remained tricky, and even in Europe conceptions are not totally clear, despite the extraordinary development of scientific knowledge since the early 20th century. Nevertheless much progress has been made, and influenza and the recurring threat it represents each year have been explained to the general public. Scientists carefully monitor the viruses and their transformations and prepare vaccines for the new strains, and doctors have convinced people of the advantage of vaccination at the right moment. Africa is a different story, and it remains difficult to compare influenza with the other enormous, overwhelming and devastating diseases that persist in contexts of malnutrition and poverty. While efforts have been made in terms of information and action regarding the major diseases, especially those that can be prevented with vaccines, and vaccination campaigns have been effective and allowed people to understand these diseases, influenza remains less well identified and cannot be considered a threat on the same level as these other terrible diseases.

When you are based in Africa and consider the messages from abroad concerning the threat of pandemic influenza and the spread of avian flu– with its possible consequences for human health on a large scale – you are first struck by the strength of these messages, the amount of underlying research and scientific knowledge, and the insistent desire to convince people of the danger and mobilize on a worldwide scale. Yet this desire to
develop international cooperation is expressed in a context where decisions are made in the Northern countries, who would seem to be the only ones to have understood the reality and amplitude of the threat.

It is important here to re-read the messages and information published in Africa on the threats and realities of influenza in the different countries: we can see how foreign this information can appear, since it mainly expresses fears that are felt elsewhere while ignoring the health preoccupations of African societies affected by other diseases. The initial explanations of the threats, along with the "strategies" recommended and the measures required – many of which can have severe economic consequences – were perceived as almost unreal and as another attempt, hidden behind the pretext of scientific knowledge, to impose measures on Africa whose relevance is neither justified nor understood.

These messages, when they were listened to, provoked fear, but also incredulity and protest, especially in the absence of any observed facts. The alarmist nature of the information was undoubtedly not appropriate to encourage the proper perception of the possible health threat. More generally, shouldn’t we recognize that these forms of scientific discourse and medical information, still prevalent, do not consider the recipients – whether potential or real patients – as free individuals able to refuse or accept, to understand and to discuss the choice of the prevention modes and possible therapies to be implemented?

Is this not a good example of a scientific and medical practice through which one can possibly inspire fear, yet still not provide the necessary information to enable people to make reasonable choices and to involve all members of the community in promoting health?

In practice, the international organizations supported the generalization of the preventive measures, especially against avian flu. Committees were set up everywhere but without any real means. They therefore remain subject to the powers from above who devise unexplained and thus poorly understood measures. The epidemiological surveillance systems set up are usually implemented by foreign expert teams who can easily be suspected of portraying the situation in an alarmist fashion. The monitoring applied to detect the first cases as soon as they arise – using technological means that are imported, often inaccessible in Africa and only available from Northern research institutes – poses real problems, as illustrated by the lack of participation of African doctors and researchers in the scientific publications on the subject.

The message is therefore imposed from abroad, based on knowledge that is also imposed and does not take into account or refute any local knowledge.

Despite the fact that they emanated from WHO channels, the initiatives proposed by Northern health authorities met with widespread incomprehension: why kill all the poultry at once, when they represent a source of income and food that would disappear with practically no compensation?

Forced slaughtering has wider consequences on food habits and economic resources, but can be understood if it is well explained and if solutions are proposed to solve the associated problems. This new type of dialogue is especially necessary since similar questions, rarely dealt with, are raised concerning food safety, which is very unsatisfactory in Africa in the absence of the appropriate regulations and technical control instruments.

Another sentiment of injustice was expressed with regard to the incessant repetition of the message concerning "the counterattack planned in the Northern countries", i.e. the stockpiling of available Tamiflu®, while one can imagine the access problems for this medication in Africa in the event of a real, serious epidemic.

The experience of the AIDS epidemic is still present in our minds, and we have seen how difficult it is to provide care and new medications when they are discovered: what will happen to the Southern countries if there is a serious influenza or avian flu pandemic? Will they again have to beg for access to the known treatments?

How can we therefore inform and raise awareness in Africa, and truly debate on the threat of an influenza pandemic? How can we produce comprehensible information and disseminate it without imposing it or only using it to justify measures decided elsewhere? And above all, how can we plan the response of health care systems already confronted with major diseases such as malaria and AIDS?

Historians and anthropologists have shown over and again that the best response is to avoid inspiring fear, and that the proper identification of a disease by society – its doctors along with the other social actors – generates a response that must not be simply technical but rather characterized by the confirmation of everyone’s responsibility to promote public health.

Recent, concrete progress made in rights and ethics also requires the setting-up of legal frameworks, indispensable so
that the management of a possible flu epidemic, in whatever form, does not compete with the treatment–prevention and care – of other diseases, to avoid once again denying human rights and the right of all human beings to the best possible care. On the contrary, this management should show a concern for others, beyond borders, shared by all of the actors committed together to making the right to good health and the respect for human life become a reality.

References


[3] Most of the research has been done in English, but more recently, French researchers have adopted new approaches to analyze the history of African health that are less focused on the successes and famous figures of colonial medicine. See Karine Delaunay, “Introduction: Faire de la santé un lieu pour l’histoire de l’Afrique: essai d’historiographie”, in Outre-Mers, n° 346-347, Dossier thématique “La santé et ses pratiques en Afrique: enjeux des savoirs et des pouvoirs, XVIIe-XXe siècles”, pp. 7-46, Paris, SFHOM, 2005.


[6] M. Echenberg, in his analysis of how the plague was handled, showed how strong the social reactions and the action of Blaise Diagne (first African leader, deputy and minister in France) and the local elite were in their refusal of and/or resistance to measures that were justified and imposed by a scientific discourse reflecting ideologies tainted with racism.


[10] See for example the press articles published since August 2005 in France referring to stocks of 200 million masks, millions of doses of Tamiflu®, the rapid propagation of the epizooty in certain regions of the world, and the millions of animals slaughtered. Then, in alarmist terms, to the arrival of avian flu in Africa in February 2006, the threat of rapid propagation, the lack of availability of the protective instruments existing in Northern countries, and the suggestion that strict measures would be taken against traditional poultry raising.

[11] See for example the results that come up when you send a query into the Medline base combining the terms “avian flu” and “Africa”.

[12] The information triggered reactions in many African countries such as a halt in the consumption of poultry and eggs, with dramatic consequences for many farmers, and for the families who drew their income from small family farms.

[13] The animal health police has existed for many years in Senegal, dating from the colonial period, it was revised just after the country’s independence in 1962, but many years passed before local veterinarians, in an international context characterized by food safety preoccupations and by strong demands from Northern countries concerning food exports, took the initiative to update the regulations, taking into account standards applied elsewhere (decree of November 4, 2002).
Table of contents

- Pandemic influenza: who should be vaccinated?
  Marc Guerrier
Debate has begun in Science magazine on the priority criteria to be applied for a possible distribution of vaccines: “Who should get the influenza vaccine (of avian origin) when not all can?”[1]. This article criticizes the recommendations of the American National Vaccine Advisory Committee and the Advisory Committee on Immunization Policy[2]. Persons aged from 6 months to 65 years, firstly those who are ill and then those in good health, occupy a higher priority position than persons under 6 months or over 65 years of age. Those from 24 months to 64 years without risk factors are the least favored in terms of priority. Emanuel criticizes the use of the principle according to which we try to save the greatest number as the basis for the recommendations. He believes that priority criteria must be based on a different principle, called the “life-cycle” principle and based on the recognition of the right to experiment all stages of life (from childhood to old age). This principle does not immediately lead to favoring sick people over the age of 65. Neither does it systematically give priority to the youngest: a weighting factor takes into consideration the way in which individuals have invested in their own lives (a six month-old baby does not have the same relationship to their own life as does a fifteen-year-old adolescent). Emanuel proposes combining the “life-cycle” principle (with the appropriate weighting: the refined life-cycle principle) with that of “public order” (to uphold society’s structures and the efficacy of the health care system). These combined principles lead to favoring an age group from 13 to 40 years of age.

Silverstein[3] refutes the idea of not giving priority to children under thirteen for the following reasons: firstly, they are an important transmission vector during pandemic influenzas, and secondly, though they may not have the same investment in their lives as older children do, their parents have a real emotional investment and a project for their child. Frey[4] objects that taking into account mortality rate variations according to age to save the greatest number of cumulative years will favor the most fragile (therefore the most elderly). Emanuel[5] states that if the cumulative number of years of life saved by a strategy based on the life-cycle principle were inferior – which he does not believe – it would nevertheless remain preferable since young people have unfulfilled lives. Finally, Galvani[6] states that vaccination of the youngest children will indirectly protect other age groups. This method would be more effective in terms of its effects on total morbidity. Emanuel[5] feels that one way to limit the extent of transmission by the youngest children is to isolate them at home. However, if a consequence of vaccinating them was to protect persons in 13 to 40 group, then it would be appropriate to do so to respect the right to life principle in all cycles of life.
**References**


**Call for articles**

**Pandémics**

is available on the Internet in French and English at: www.espace-ethique.org/fr/grippe.php

Click on the PDF link: Pandemics.

The editorial team at **Pandémics** would be happy to receive proposals for original articles devoted to the ethical and societal issues raised by the possibility of an influenza pandemic. Articles chosen by the reading committee will be published in French and English. The texts must not exceed 15,000 words, must be written either in French or in English, and must be sent by E-mail with full contact information concerning their authors to: journal.pandemics@sls.aphp.fr.

**Contact editorial team:**

**Pandémiques**

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75475 Paris Cedex 10
journal.pandemics@sls.aphp.fr
T. +33 (0)1 44 84 17 81
Reference sites

Web site for the Observation & Reflection Platform on Pandemic Influenza, Ethics and Society
www.espace-ethique.org/fr/grippe.php
Espace éthique of the Assistance Publique – Hôpitaux de Paris, Paris-Sud 11 Ethics Research Department
Site dedicated to ethical and society-based approaches to pandemic influenza. On-line publication of the PANDÉMIQUE S/PANDÉMICS

The Avian Flu news site
http://grippeaviaire.veille.inist.fr
French national scientific research centre/INIST

The news site devoted to avian flu was created to anticipate questions from the general public. It was in fact set up in February 2004, at which time it provided a summary document concerning avian flu and its transmission to human beings and relayed news about the first alerts in Asia.

Given today’s gap between science and society, and questions from the public about some of the current issues very broadly relayed by the medias, the objective of this avian flu site (http://grippeaviaire.veille.inist.fr) is to facilitate access to information produced by international research. Information is collected from a wide variety of scientifically proven sources, summarised and put into French by specialists in the field.

The site was created and expanded to encourage access to scientific and medical research news on a topic that is currently at the centre of society's concerns. The target readers range from health or information professionals to members of the general public keen to diversify their sources of information.

The site is accessed free of charge and provides many documentary resources and relevant links as well as valid scientific news from international sources.

Since it was put on line, the site has been updated daily by a doctor, a pharmacologist and a biologist. As well as tracking current issues, the site offers access to many other sources of information (links to government agencies, press sites, bibliographic references to scientific articles, etc.).

Technical work has gone into facilitating the way content from external sources is put together and into providing different information formats (subscription to Real Simple Syndication (RSS) web feeds, summary file in HTML or PDF format, etc.).

Two points demonstrate the relevance of this approach to providing answers to the avian flu questions and concerns for health and information professionals and members of the general public keen to diversify their sources of information:

• the increasing number of hits: an average of 130 hits a day so far.

Some 160 articles and news briefs have been published since the site was put on line. It includes a great number of articles, a complete summary file about disease transmission to human beings, a detailed webography and a glossary of frequently used terms.
Observation & Reflection Platform on Pandemic Influenza, Ethics and Society

In early 2006, the Paris-Sud 1 University Ethics Research Department and the Espace éthique of the Assistance Publique-Hôpitaux de Paris decided to adopt an interdisciplinary approach to the ethical and social issues of pandemic influenza and set up an expertise network. Over the coming months, this network will be developed, aiming notably to work at the international level with structures or authorities involved in the same field of action. Its missions are to monitor developments, identify the questions arising with respect to the influenza pandemic, analyse proposals put forward by public authorities, contribute to research and publication of information, awareness-raising, public debate and choices.

Contact: marc.guerrier@sls.aphp.fr

Monday 26 June 2007
2:30
Ethical and Pandemic Influenza - 1 - Ethical stakes, technological challenges

Introduction
Jean-Claude Magendie
President of the Paris-Court

1.00
Session chair: Patrick Hardy
Professor of Psychiatry, Paris-Sud University, Center Hospitalier Universitaire Hospital (CHU) de Saint-Louis, Paris-Sud 1 University

1.15
Richard Harrow
Professor of bioethics, La Sapienza University of Rome, Department of Bioethics, Human Rights and Health Law, Ethics Research Department, Paris-Sud 11 University, France

1.30
Didier Sicard
President of the national AIDS Council, Department of Ethics, Human Rights and Health Law, Ethics Research Department, Paris-Sud 11 University, France

1.45
Jean-Pierre Fleury
Professor of Public Health, Ibadan University, Nigeria

2.00
Arthur Fagg
Professor of Medicine, Paediatric Intensive Care Unit, Department of Ethics, Human Rights and Health Law, Ethics Research Department, Paris-Sud 11 University, France

2.15
Christian Haas
Chair of the Ethics and Pandemic Influenza Platform, Ethics Research Department, Paris-Sud 11 University, France

3:00
Discussion

Tuesday 27 June 2007
2:30
Ethical and Pandemic Influenza - 2 - Pandemic influenza and the healthcare system

Introduction
Françoise Domazetis
Director of the National Authority for Health Environment Association, director of the Health Ethics Unit, AP-HP, Paris - Sud 11 University

2:45
Vladimir Dab
Chair of the Ethics and Pandemic Influenza Platform, Ethics Research Department, Paris-Sud 11 University

3:00
Discussion

Wednesday 28 June 2007
2:30
Ethical and Pandemic Influenza - 3 - International ethical stakes

Introduction
Elisabeth G. Sledziewski
Professor of Internal Medicine, Cochin University Hospital, Paris-Sud 11 University

2:45
Bernard Devalois
Secretary General of the French National Institute for Advanced Studies on the Sciences and Society, the Espace éthique of the Assistance Publique-Hôpitaux de Paris

3:00
Discussion

Friday 30 June 2007
2:30
Ethical and Pandemic Influenza - 4 - Pandemic influenza and ethics

Introduction
Elisabeth G. Sledziewski
Professor of Internal Medicine, Cochin University Hospital, Paris-Sud 11 University

2:45
Didier Tourancheau
Director of the Epidemiological and Prevention Research Ethics Research Department, Paris-Sud 11 University, France

3:00
Discussion

Saturday 1 July 2007
2:30
Ethical and Pandemic Influenza - 5 - Pandemic influenza and the research ethics

Introduction
Jean-Claude Magendie
President of the Paris-Court

2:45
Jean-Pierre Fleury
Professor of Public Health, Ibadan University, Nigeria

3:00
Discussion

Sunday 2 July 2007
2:30
Ethical and Pandemic Influenza - 6 - Pandemic influenza and the daily life of patients and hospital staff

Introduction
Jean-Claude Magendie
President of the Paris-Court

2:45
Pascale Ehrmann
Professor of Public Health, Ibadan University, Nigeria

3:00
Discussion

Monday 3 July 2007
2:30
Ethical and Pandemic Influenza - 7 - Pandemic influenza and the research ethics

Introduction
Jean-Claude Magendie
President of the Paris-Court

2:45
Jean-Pierre Fleury
Professor of Public Health, Ibadan University, Nigeria

3:00
Discussion

Tuesday 4 July 2007
2:30
Ethical and Pandemic Influenza - 8 - Pandemic influenza and the research ethics

Introduction
Jean-Claude Magendie
President of the Paris-Court

2:45
Jean-Pierre Fleury
Professor of Public Health, Ibadan University, Nigeria

3:00
Discussion

Wednesday 5 July 2007
2:30
Ethical and Pandemic Influenza - 9 - Pandemic influenza and the research ethics

Introduction
Jean-Claude Magendie
President of the Paris-Court

2:45
Jean-Pierre Fleury
Professor of Public Health, Ibadan University, Nigeria

3:00
Discussion

Thursday 6 July 2007
2:30
Ethical and Pandemic Influenza - 10 - Pandemic influenza and the research ethics

Introduction
Jean-Claude Magendie
President of the Paris-Court

2:45
Jean-Pierre Fleury
Professor of Public Health, Ibadan University, Nigeria

3:00
Discussion

Friday 7 July 2007
2:30
Ethical and Pandemic Influenza - 11 - Pandemic influenza and the research ethics

Introduction
Jean-Claude Magendie
President of the Paris-Court

2:45
Jean-Pierre Fleury
Professor of Public Health, Ibadan University, Nigeria

3:00
Discussion

Saturday 8 July 2007
2:30
Ethical and Pandemic Influenza - 12 - Pandemic influenza and the research ethics

Introduction
Jean-Claude Magendie
President of the Paris-Court

2:45
Jean-Pierre Fleury
Professor of Public Health, Ibadan University, Nigeria

3:00
Discussion
The human, social and political consequences of a possible pandemic influenza deserve better treatment than a few formal resolutions or the organization of debates among specialists. We must create the conditions to allow the involvement of all levels of society, to foster creativity and encourage participation. While all sorts of plans are being drafted to reassure and organize, using coherent intervention methods and risk-mitigating strategies, ethical approaches have so far been quite sparse. They are, at best, limited to a few humanitarian generalities or vague considerations.

The values, resources and references of democracy will be directly challenged by a disaster that may shake its foundations. These are the stakes: how can we, as democrats, fight against a pandemic, which like other threats, can affect our principles?

PANDEMICS® will contribute to the dissemination and confrontation of opinions and proposals developed in France and throughout the world, in particular in the fields of human and social sciences.