

**NCIOM/DPH TASK FORCE ON ETHICS AND  
PANDEMIC INFLUENZA PLANNING**

June 7, 2006

NC Hospital Association, Cary, NC

**Meeting Summary**

**WELCOME AND INTRODUCTIONS**

**Leah Devlin, DDS, MPH**

State Health Director

Division of Public Health

NC Department of Health and Human Services

**Rosemarie Tong, PhD**

Center for Professional and Applied Ethics

Department of Philosophy

University of North Carolina at Charlotte

Drs. Devlin and Tong welcomed the Task Force members. Dr. Devlin remarked on the secondary transmission of the bird flu, which likely does not represent a mutation of the virus. She also commented on the inadequacy of our state lab and medical office, which she and others are attempting to address in the state legislature. She encouraged everyone to contact his/her legislators about the issue. Dr. Tong encouraged us to maintain focus on the big picture of ethical principles and noted that the focus of the day's morning session will be primarily on general concepts and the afternoon will be on the duty of healthcare workers to provide care during a pandemic influenza.

**GOVERNOR'S AUTHORITY UNDER EMERGENCY MANAGEMENT ACT, NCGS 166A**

**Cheryl Perry, JD**

Assistance Attorney General

Crime Control Section

NC Department of Justice

Cheryl Perry, Assistant Attorney General from the NC Department of Justice's Crime Control Section, provided information on the Governor's authority in disasters and emergencies. She also discussed pertinent issues for individuals and some powers of the State Health Director and State Veterinarian. Laws concerning emergency management are primarily found in two places in the North Carolina statutes: Chapter 166A and Article 36A of Chapter 14. Chapter 166A addresses emergencies that would arise from a pandemic influenza. A pandemic flu would be listed as a type I, II, or III disaster, but this classification type is only relevant for the level of state/federal disaster assistance provided. Type I disasters would not receive federal assistance, while Types II or III would qualify for federal assistance. Chapter 14 primarily gives authority to local governments to control emergencies. The Governor can only use the authority in Chapter 14 if local control of the emergency is insufficient.

The Governor has relatively broad authority during a disaster, following a disaster, or when there is imminent threat of a disaster. The Governor can require public workers to work; and restrict movement; require, confiscate property, with provision of compensation which he determines; and, through the emergency management program, coordinate and use any private facility services and property. The Governor also has the authority to take other necessary steps to promote and secure the safety and protection of the civilian population.

Private individuals who do not comply with any provision of a gubernatorial proclamation can be found guilty of a Class Two misdemeanor. Private individuals who help others are immune from legal liability, as are volunteer healthcare professionals working during a disaster, with some exceptions. Healthcare professionals are not immune when working during a disaster if they are compensated for their services or in the case of gross negligence, wanton conduct, or intentional wrongdoing. All functions and activities relating to emergency management are governmental functions. Emergency management workers, including persons performing emergency healthcare services, are not liable, except in cases of willful misconduct, gross negligence, or bad faith when performing emergency management services. An authorized emergency management worker in the course of performing his duties also does not need a license to practice any professional, mechanical, or other skill for which a license normally would be required. However, demonstrating that one is an authorized emergency worker may prove difficult because it requires demonstrating that one was subject to the order or control of the State, county or city or acting pursuant to a request by the State, city or county and complying with or reasonably attempting to comply with an order, rule or regulation promulgated pursuant to the provisions of Chapter 166A or pursuant to an ordinance relating to emergency management measures enacted by a city or county.

During a disaster, the State Health Director has the authority to quarantine and isolate individuals or groups. The Governor has the authority to issue a proclamation forbidding importation of any infectious or contagious poultry, and the State Veterinarian also can implement emergency measures and procedures. The State Veterinarian, after consultation with the State Health Director, can quarantine animals and inspect facilities without a warrant.

#### **COMMENTS/QUESTIONS**

Dr. Devlin commented that the state does have a pandemic influenza plan, and that the State Health Director has long had the authority to quarantine and isolate, as have the local health directors. In 2003, the state overhauled its public health and communicable disease laws and first used its authority to quarantine and isolate with SARS. Dr. Devlin also noted that there are currently two related issues in the General Assembly this session: provision of embargo authority for local health departments and their regional supervisors to allow them to prevent sale of a food items that they fear may be contaminated, and immunity from liability within the state for healthcare workers deployed from the state's own hospitals and health departments.

The Task Force had several questions concerning the Governor's authority and decisions during a crisis situation. Ms. Perry suggested that the Governor's authority to protect the public during an emergency may be sufficiently broad to give him the authority to compel private individuals to work during an emergency. However, this power has never been tested. The Governor has the authority to waive licensure laws for emergency management workers, which could be exercised to allow a broader group of individuals to serve in healthcare settings. The NC Medical Board also has the authority to waive licensure rules for physicians, physician assistants, and nurse practitioners during an emergency. For example, the NC Medical Board could waive the licensure rules to allow retired physicians to practice during an emergency. However, other healthcare professional licensure boards, such as nursing and pharmacy, do not have the same authority.

Ms. Perry suggested that the Governor could order all employees of a private hospital to report to work under two provisions, one in the state of disaster law and one in the state of emergency law.

The penalty for not reporting to work would be a Class Two misdemeanor, as specified in the state of emergency statutes. If the Governor orders businesses to close, the businesses possibly could get Small Business Administration assistance if the event receives a major disaster declaration. If the event does not receive a major disaster declaration, the business would have to try to show that they are entitled to compensation under Chapter 166A-11, but that may prove a challenge since that statute doesn't specifically address compensation to businesses.

Other questions from the Task Force regarded immunity from liability for healthcare workers assisting in a crisis situation. If the physicians are emergency management workers, they have immunity except for gross negligence. A determination of gross negligence depends upon the standard of care, which changes during an emergency. Thus, a judge would evaluate the standard of care in the specific situation to determine if the immunity should be upheld and the actions were not grossly negligent for that situation. Additional protection is available for emergency management workers through Chapter 166A. The Federal Volunteer Protection Act also provides some immunity. Additionally, there is a national effort to develop an advanced registry for volunteer healthcare professionals, though there is some question whether all states will be able to share the information with each other. Four of the states in Region 4 (the southeastern states) have agreed to buy the same system and share that information with each other.

#### **DISCUSSION OF ETHICAL VALUES**

Drs. Pam Silberman and Rosemarie Tong facilitated a discussion to determine if the ethical guidelines developed thus far are the correct ones, with a reminder that several values were put in as placeholders and may change after more detailed discussion. The guidelines, based on the Toronto document, are being developed in advance to help government officials make tough choices when the situation arises. The conclusions reached at the meeting are described below.

Key ethical principles include protection of individual liberty, protection of the public from harm, proportionality of response, privacy protections, reciprocal obligations, duty to work for healthcare workers, duty to work for other critical workers, equity, trust, collaboration, stewardship, reasonableness, transparency, inclusiveness, responsiveness, accountability, keeping public informed, economics/timeliness.

- Individual liberty outlines basic *values* that should be respected in healthcare, such as access to care and confidentiality, but which may need to be restricted to address broader societal good. Any restrictions to personal liberty should be necessary given the nature of the pandemic influenza outbreak; employ the least restrictive means needed to protect the public, and; be applied equitably to similarly situated people regardless of race, color, religion, nationality, sex, age, disability, geography, ethnicity, sexual orientation, or economic status.
- Protecting the public is a fundamental social value. When taking actions that impinge on individual liberties, governmental authorities should balance the harm to the public with harm to the individual; provide reasons for voluntary compliance; employ the least intrusive means needed; discontinue or limit restrictions as soon as circumstances permit; specify penalties for non-compliance, and; establish mechanisms to address inequitable imposition of restrictions or penalties.
- Proportionality is important because restrictions to individual liberty should not exceed what is needed to address actual or imminent risk or critical needs of the community.

- Any disclosure on a person's privacy (medical and other) should be limited to the information that is pertinent and relevant to the emergency; employ the least intrusive means needed to protect the public; be consistent with what the law permits; be as confidential as circumstances permit, and; be discontinued as soon as circumstances permit.
- With respect to reciprocity, society should support those who bear a disproportionate burden in protecting the public, and take steps to minimize this burden as much as possible. Individuals with disproportionate burdens may include: infected persons, healthcare workers, emergency management workers and other first responders, workers in other critical industries or key professions, or healthcare professionals, patients, and their families. Reciprocity may require additional compensation, services, care, or special considerations for disproportionately burdened individuals.
- Healthcare providers have a duty to work because inherent in a healthcare professional's code of ethics is the duty to provide care and to respond to human suffering. This obligation exists even in the face of increased risk to the provider. The duty to provide care during a pandemic must be balanced against the ability to provide care to patients in the future. Healthcare organizations and institutions, government, and society owe support to healthcare workers and/or their families at increased risk during a pandemic outbreak (i.e., reciprocity).
- Other critical workers have a duty to work because certain basic goods and services must be available to the public during a crisis, in order to ensure basic societal needs are being met (e.g., food, water, utilities). Emergency management workers may be needed to maintain calm, or to carry out protection orders. Employers and society owe support (reciprocity) to key workers who may be putting themselves or their families at increased risk during a public health emergency.
- Values of distributive justice or equity state that all people have equal moral worth. However, during a pandemic, all individuals may not be able to receive all needed healthcare services. Decisions about who to serve during a pandemic should not be based on an individual's race, color, religion, nationality, disability, sex, age, economic status, sexual orientation, geography, or whether the individual is insured, unless there are specific clinical reasons for why different groups should be treated differently. Equity issues may also arise in the workplace, e.g., if certain critical workers are allowed to stay home (pregnant women or single parents), or if certain workers are required to work longer hours.
- Trust is essential to a relationship between clinicians and patients, organizations and their staff, and governmental organizations or officials and the public. Trust is indispensable for expectations of compliance. Trust, during a crisis, is enhanced by ensuring transparency, equity in the application, restrictions, and/or allocation of limited resources, reciprocity, etc.
- Response to a pandemic influenza outbreak requires collaboration and cooperation within and among governmental organizations, public and private healthcare institutions and professionals, other public and private organizations, and among individuals.
- In terms of stewardship and leadership; those involved in resource allocations, whether governmental officials, private entities, or individuals should be guided by the notion of stewardship, or the responsibility to take good care of entrusted resources. Decisions involving resource allocation should be made to achieve the best public health outcomes (common good).

- In order to ensure reasonableness, decisions should be based on evidence, principles, and values that are relevant to meeting the public's needs in a pandemic influenza outbreak; credible, accountable, and trustworthy; and made objectively and impartially.
- In order to ensure transparency, the process by which decisions are made should be open to the public for scrutiny, and the basis for the decisions should be publicly accessible. Information should be provided to the public so that they can make informed choices.
- Truth-telling involves providing accurate information in a timely and responsible manner to keep the public informed.
- Inclusiveness requires that decisions consider public input; decision makers have a responsibility to inform the general public and engage relevant stakeholders in the course of the decision making process; and special efforts should be made to include representatives from marginalized and vulnerable populations early in the policy discussions.
- Responsiveness ensures that there are opportunities to revise decisions as new information emerges throughout a pandemic influenza outbreak; mechanisms to address disputes and complaints; and the review process is balanced with the need to make quick decisions during a pandemic.
- Accountability requires systems to ensure that decision makers are answerable for their actions and inactions, and individuals, businesses, and institutions should not unfairly profit as a result of a pandemic influenza outbreak.
- Timeliness ensures that actions are taken quickly to serve public good.

**PANEL DISCUSSION: ETHICAL RESPONSIBILITY OF HEALTHCARE WORKERS TO WORK; RESPONSIBILITY OF HEALTHCARE INSTITUTIONS TO SUPPORT HEALTHCARE WORKERS AND OTHER CRITICAL WORKERS DURING PANDEMIC**

**Janelle Rhyne, MD, FACP**, NC Medical Society, NC Medical Board

Dr. Rhyne spoke on the obligation for physicians to work. There are no licensure requirements for physicians to work during a crisis. The NC Medical Board recognizes the physician's right to choose patients and to terminate the professional relationship with them when he or she believes it is best to do so, but the physician needs to provide continuity of care when terminating the relationship. The Medical Board does believe that it is the physician's duty to provide care when needed or to ensure that appropriate back-up care is available during or outside of normal office hours. The patient should be aware of how to secure such care.

Regarding an ethical obligation to provide care in a disaster situation, the American Medical Association's (AMA) Statement E-9.067, the American College of Physicians (ACP) ethics manual, and the American College of Emergency Physicians' ethics statement state that physicians do have an ethical obligation to provide care even at risk to self. However, they also note that the obligation and its immediate benefits to individual patients should be balanced against the ability of the physician to care for patients in the future, since physicians are a limited resource. Thus, physicians are encouraged to work in disaster situations but to take the proper precautions.

The physician's obligation to work has to appeal to a sense of professionalism since that is the basis of medicine's contract with society. The social contract between physicians and society

places the interest of the patient above that of the physician. Physicians do have an obligation to provide care, but institutions also have an obligation to ensure a safe working environment.

**Linda Burhans, Practice Consultant, NC Board of Nursing**

Ms. Burhans spoke on the obligation for nurses to provide care during emergencies and disasters. There are no NC Board of Nursing licensure requirements for nurses to provide care during a crisis, nor do the American Nurses Association or NC Nurses Association express a duty to provide care during a crisis. Correspondingly, there are no defined professional sanctions if nurses choose not to provide care, though they may face employment sanctions if their employer orders them to work and they do not. The American Nurses Association does have a code of ethics and social policy statement that provide some general guidance relevant to nurses' obligations, including maintaining a primary commitment to the patient.

In her experience there generally is a significant response by hospital nurses to crisis situations. However, there is a sense from experience that support in other community settings can be very inadequate. Also, the response could be different in a pandemic because of nurses attempting to balance competing priorities to patients and to their families. Often, organizations are able to put processes in place to assist with these concerns, but that may be more difficult in a pandemic situation; provision of alternate child and elder care may prove to be one of the largest challenges.

There are several unique concerns in a pandemic. One concern is that some nurses may refuse to care for patients because they do not think they agreed to assume that kind of risk when they took on the profession of nursing. Another concern is that maintaining appropriate scope of practice and standards of care could be serious issues, especially if there are "working sick" leading to decreasing numbers of available nursing resources.

**Tom Williams, RRT, RCP, NC Respiratory Care Board, NC Society of Respiratory Care**

Mr. Williams spoke on the obligations to work for respiratory therapists. There is no specific statement about the requirement for respiratory therapists to work in a crisis, but there are some statements about the ability to provide temporary licenses to practitioners from other states. There are no provisions to address behavior in a crisis situation, but there are general provisions with penalties for abandonment of patients. However, for abandonment to apply, the respiratory therapist first would have had to accept the assignment. Discussion of the flu pandemic and their response to it as a profession is on the agenda for the AARC national meeting at the end of July. The NC Respiratory Care Board and NCSRC also are willing to consider adding provisions to their code of ethics to address duty to provide care.

The American Association for Respiratory Care has published guidelines for ventilator acquisition in the case of a pandemic. However, training of professionals to use ventilators is an important issue, especially since there are shortages of respiratory therapists in many areas.

**Barbara Bisset, PhD, MS, MPH, RN, Executive Director, Emergency Services Institute, WakeMed**

Dr. Bisset spoke on the responsibilities of healthcare institutions to their workers to ensure their safety. Healthcare institutions have an obligation to make sure the workplace is safe for healthcare workers; they have to ensure "scene safety." These responsibilities include provision of personal protective equipment (PPE). In the event of a shortage of PPE, the healthcare institution needs to implement appropriate policies to continue to ensure the safety of its

workers. Institutions also have an obligation to have very detailed planning such that employees know what their responsibilities are during a disaster. Institutions have an additional obligation to provide good concrete personal preparedness planning to staff because if they are not prepared they will not be focused on their job.

Institutions have an obligation to minimize the number of staff exposed to disease; provide optimal protection for those who are providing care; reduce meetings/face-to-face contacts; ensure good workforce hygiene and let those who can work from home do so; develop policies prior to an event, especially regarding compensation, sick leave, and absences towards a goal of equality in how people are managed; have multiple support structures in place, including support for families of staff members; identify and train other critical workers to fill in if individuals do not show up to work; network and collaborate; and communicate honestly and frequently with staff. From an ethical perspective, there is a concern surrounding how to provide the mental health, social health, and faith-based needs of the employees who have to make difficult decisions in a crisis.

### COMMENTS/QUESTIONS

Several of the Task Force's comments and questions centered around the roles and duties of specific groups. All employees need to be a part of this pandemic response.

- Maintenance personnel are and should be involved in planning. Their responsibilities should be clarified. They will receive the same protection and support as other staff.
- Nurses have the same duty not to abandon patients as respiratory therapists.
- Pharmacists will play a vital role in a disaster. Pharmacists are trained in screening and in recommendation and monitoring of appropriate therapy; they have worked closely with the Medical Board and Nursing Board for some extended privileges. In terms of duty to work, they are among the most accessible healthcare professionals and as such are put at risk with how patients respond to crisis situations. As a result, the duty to work for community pharmacists poses health and safety risks. Another concern is how pharmacists and others will get necessary medications to people in quarantine.
- According to the National Association of Social Workers, social workers have an employer-based duty to provide care, but there are no penalties for not reporting in crisis.
- Regarding employers, the Occupational Safety and Health Administration (OSHA) has very strong regulations and a reputation of being inflexible concerning their obligation in the area of personal protective equipment. Employers should try not to violate OSHA regulations, but there could be a national shortage of masks and a used mask is better than no mask. Practicality is not in OSHA policy limits, though the situation may be different if there is a national epidemic.
- Behavioral health services during an emergency should only be provided by persons with proper training, but partnerships with local behavioral health professionals should be established now, prior to an outbreak.

Dr. Silberman summarized the discussion by stating that it seems that under licensure rules there is no obligation to work and no ramifications if one does not work. However, under professional obligations, there are implicit or explicit ethical obligations to work regardless of health status. If one does not follow these ethical guidelines there are no licensure ramifications, with the exception of emergency physicians, though there may be job ramifications.

## **DISCUSSION**

### **Healthcare Professionals: Duty to Work**

Discussion began with the statement that “healthcare professionals have a collegial duty to accept a proportional share of the risk that their profession exposes them to.” However, there is a question whether healthcare professionals are freely choosing the assumed risk. There is not necessarily an implicit assumption that they will assume the same burden that previous generations may have assumed because the physician’s mentality of work has changed from seeing it as a professional calling to an obligation to a job.. Also, the assignment and assumption of risk is not evenly distributed. A professional’s skill set may preclude him or her from assuming the risk of others and fulfilling his or her role to exercise his or her collegial duty. A notion of professionalism is inherent in the duty to care, but there are different levels of duty to care and no absolute duty of care.

Healthcare professionals assume an obligation to act in the best interests of the sick. There is a notion that the licensure monopoly, which confers on healthcare professionals a monopoly to do certain activities that the public cannot, leads, through the social contract, to a heightened responsibility to provide care that the public cannot during a crisis. Licensed professionals are allowed some benefits and privileges, and it would seem that a duty to society over themselves arises in return for the privilege society grants. However, some healthcare professionals may not be aware of the risk factors associated with their job.

Duty to work must be balanced against other considerations. The duty to work should include supporting the employee in caring for their families in addition to providing care for the ill. Management/leadership has a duty to help workers with difficult decisions. Healthcare workers have the right to protect their own life, and there must be compensatory measures for the risk, such as disability insurance or worker’s compensation.

There are three different kinds of duties: professional (because of licensure), contractual (as an employee of an employer), and human duties (those any individual has to another). Other unlicensed healthcare workers have a duty to the mission of their place of employment; institutions need to educate healthcare workers during training of their duty to provide care and continue working even when risk is involved. The duty to work is part of acculturation and professional responsibility for the healthcare professionals, and part of employment at a healthcare institution for the unlicensed workers. However, the obligation to do work does not necessarily mean it must be done in the same way. Institutions should outsource responsibilities and allow those employees who can, to do work from home.

## **TASK FORCE ATTENDANCE**

*Task Force members: Leah Devlin (co-chair), Rosemarie Tong (co-chair), James Ball, Granger Barrett, Barbara Bisset, Jennifer Brandenburg, Allison Breedlove, Linda Burhans, Sally Cameron, Dorothy Cilenti, Lynne Doss, Jeffrey Engel, Leigh Foushee, Merle Green, Merrill Holden, Chuck Liford, Jill Moore, John Morrow, John Moskop, George Reed, Janelle Rhyne, Don Ritter, Philip Rosoff, Rudy Rudisill, Jane Stein, Jim Thomas, Tom Williams, Chuck Willson*

*Steering committee, staff, and other interested guests: Violette Ajiboye, Aaron Augustino, Dan Blau, Steve Cline, Kristen Dubay, Joanna Forrester, Thalia Fuller, Scarlet Gardner, Natasha Harrison, Kathy Heilig, Mark Holmes, John Jordan, James Markham, Lillie Peebles, Cheryl Perry, Pam Silberman, Danae Sjogren, Joseph Talley, Kristie Thompson, Andrew Werbrock, Tom Williams*