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ORIGINAL RESEARCH

"With Human Health It's a Global Thing": Canadian Perspectives on Ethics in the Global Governance of an Influenza Pandemic

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Abstract We live in an era where our health is linked to that of others across the globe, and nothing brings this home better than the specter of a pandemic. This paper explores the findings of town hall meetings associated with the Canadian Program of Research on Ethics in a Pandemic (CanPREP), in which focus groups met to discuss issues related to the global governance of an influenza pandemic. Two competing discourses were found to be at work: the first was based upon an economic rationality and the second upon a humanitarian rationality. The implications for public support and the long-term sustainability of new global norms, networks, and regulations in global public health are discussed.

Keywords Global health · Pandemic influenza · Global health ethics · Solidarity · Deliberative methods

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Introduction

Public health is inherently global in the 21st century, particularly with respect to outbreaks of infectious disease. Preventing the spread of infectious disease pandemics is a fundamental obligation of national governments; however, effective response to pandemics cannot be accomplished independently. Rather, the preparation and response to pandemics require coordinated efforts at all levels of government, in addition to international cooperation. Porous borders, mutual vulnerability, and both economic and scientific interconnectedness mean that communication, cooperation, and mutual support are needed between countries in concert with international organizations (University of Toronto Joint Centre for Bioethics Pandemic Influenza Working Group 2005).

New global norms, networks, and regulations provide us with an unprecedented ability to detect emerging outbreaks and to intervene to limit their impact. International law and pandemic plans have created a common structure and set of procedures for global cooperation in response to outbreaks, and a new era of international collaboration has begun (Santos-Preciado et al. 2009). This has been accompanied by new

commitments to expand international assistance to build public health capacities such that all countries are able to prepare for, respond to, and recover from pandemics (McDougall, Upshur, and Wilson 2008).

However, the current state of global health inequities means that while resources necessary for responding to a pandemic may be in short supply in Canada and other wealthy countries, they are vanishingly scarce in poorer countries. As a result, much of the world's population will face pandemics empty handed, without the tools needed to identify, prevent, and treat infections. While some countries are providing public health advice and emergency response support, others are simultaneously imposing protectionist measures to isolate affected countries. Consequently, poorer countries may see no alternative but to impose disproportionate measures of their own, which may include applying domestic containment strategies that breach human rights (McDougall and Wilson 2007) or withholding biological information and virus samples needed to track and combat infectious diseases (The Lancet 2007). It has been argued that the international community, and in particular Canada and other countries of the G8 and Organisation for Economic Cooperation and Development (OECD), has a shared responsibility to make good on its legal obligations to enhance global health collaboration and moral commitments to equal human worth and dignity (Labonte, Schrecker, and Sen Gupta 2005).

Significant ethical questions remain regarding the role wealthy countries ought to play in aiding the global response to pandemics. As part of its research platform, the Canadian Program of Research on Ethics in a Pandemic (CanPREP), funded by the Canadian Institutes of Health Research, sought to elicit views from the public about ethical issues related to pandemic influenza, including the role of global governance and responsibility. Little is known about how these new regulations and formalized international obligations resonate with the public. In this paper, we present CanPREP's findings from town hall discussions on global governance and discuss their moral significance.

Methods

Sample Recruitment and Setting

The research team conducted three town hall meetings between June 2008 and May 2009, which were held in major cities across Canada: Vancouver, British Columbia; Winnipeg, Manitoba; and Saint John, New Brunswick. These data were collected prior to, and during, the H1N1 influenza pandemic, which makes this a unique set of data owing to the participants' exposure to media and public health messaging prior to the town hall meetings. As a result, pandemic influenza was likely not a new topic to them, but rather one to which they brought some previously held opinions. Participants were recruited from the general public in each location using social networking websites (e.g., Facebook) and local newspaper advertisements. Additionally, local study collaborators assisting in the organization of the town halls used snowball sampling to further recruit participants. Individuals were eligible to participate if they were over the age of 18, spoke fluent English, and had no relationship with the study investigators. In total, there were 63 participants across the three town halls: 18 in Vancouver, 25 in Winnipeg, and 20 in St. John. Participants were randomly assigned to separate focus groups on each topic: duty to care, use of restrictive measures, priority setting of scarce resources, and global governance. A total of 14 individuals attended and participated in the global governance focus groups: four in Vancouver, five in Winnipeg, and five in Saint John. No demographic information was solicited from the participants (e.g., ethnicity, income, etc.). However, based on self-reports during the initial round of introductions at the start of each focus group discussion, the participants were primarily middle-aged, ranging in age from their early 20s to late 80s, and divided equally among those who were currently employed and those who were retired or not employed. Several reported a history of community service work (e.g., as a community board member) or employment in the public sector. Several participants had a background in health care, but the majority did not. Participants were provided a travel voucher to cover travel costs incurred by attendance but were not paid for their participation.

Data Collection and Analysis

This paper reports the findings of the global governance focus group meetings that met at each town hall. Findings from town hall meetings focusing on other ethical issues during a pandemic, including health care workers' duty to care (Bensimon et al. 2012), the use of restrictive measures (Smith et al. 2012), and priority setting of scarce resources (Silva et al. 2012), have been

published elsewhere. At each town hall meeting, participants were randomly divided into groups of five to eight people and were asked to deliberate on the ethical issues associated with an assigned case scenario previously developed collaboratively by the research team (in this case, the scenario of "global governance"—see Appendix 1). Data were then collected through day-long focus groups (lasting approximately eight hours) facilitated by a member of the CanPREP team using the case scenarios as the stimulus object or focusing component (Millward 2012). Focus group guides (see Appendix 1) were used by the facilitators with prompts that aimed to encourage deliberation on the ethical issues without altering the natural flow of conversation among participants. The scenario on global governance was designed such that it would introduce new information throughout the day (referred to by team members as "reveals"—see Appendix 1) in order to explore whether additional details would alter the opinions and arguments of participants. At the end of the day, all four focus groups reconvened to debrief and further discuss the key ethical issues that were raised in each of the separate focus groups. All focus groups were audio recorded, transcribed verbatim, and verified by research team members.

Focus groups aim to build conversation among participants as opposed to conversation between the focus group facilitator and individual participants. The "interaction element" between participants is important in understanding how focus groups can be used to generate evidence (Morgan 2010). As argued by Morgan (2010), participants "own" dialogue when they are "electrified" by a topic (in this case the initial scenario—see Appendix 1) and subsequently proceed to "extend, elaborate and embroider" (Wilkinson 1998, 337). Thus, the role of the facilitator in each focus group was to maintain the focus with "specificity, range, and depth" (Millward 2012, 427) in an unobtrusive and subtle way. Participants were encouraged to direct conversation toward each other, not the facilitator. The facilitators were knowledgeable about global health governance and able to provide factual information when needed but without attempting to unduly influence the conversation.

A thematic content analysis of each transcript within and across all town hall meetings was then conducted in order to identify convergences across the meetings and divergences specific to particular focus groups. The analysis proceeded according to the following four steps: (1) Each author independently coded each transcript, one town hall meeting at a time; (2) a shared coding framework for each town hall meeting was developed collectively based on each individual's independent codes; (3) codes were collapsed into themes for each town hall meeting, repeating the process for all three meetings; and (4) themes were generated across town hall meetings.

The trustworthiness of our analysis was ensured through a series of peer consultation sessions—presenting and discussing our findings with the larger CanPREP research team—and prolonged engagement with the data both individually and as a group (Lincoln and Guba 1985). The research team met at each stage of analysis in order to discuss interpretations of the results and consider themes that were emerging from the data. Detailed team notes also were kept at each stage of the analysis, including which codes were added, removed, or collapsed, in order to establish an "audit trail" (Guba and Lincoln 2005).

Ethics

This study received ethics approval from the Health Sciences Research Ethics Board at the University of Toronto, which follows the guidelines outlined in the Canadian government's Tri-Council Policy Statement on research involving human subjects (Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, and Social Sciences and Humanities Research Council of Canada 2010). All participants were informed of possible benefits and risks, confidentiality and privacy, and the ability to withdraw from the study. All participants provided written consent.

Results

The most important finding was that there were two competing discourses that emerged from the data. The first was based upon what we are calling an "economic rationality" and the second upon a "humanitarian rationality." This is not to say that any one participant embodied one rationality consistently over the other throughout the course of the day. Indeed, these data show the flaw in the dominant economic premise of egoism in human behavior (Sen 1977) by demonstrating how one person could hold a humanitarian and an

egoistic disposition at once. However, it was apparent that some participants were more comfortable thinking in predominantly economic terms rather than in explicitly moral terms. This reluctance to engage in a process of moral discernment is not really surprising and is consistent with the authors' previous experiences with conducting qualitative research on ethical issues. However, it is significant that while the morning sessions were often dominated by an economic discourse, there was a gradual shift to a humanitarian discourse toward the end of the day in each session.

Elements of an Economic Rationality

One of the two dominant themes that emerged from these data was that there was an economic rationality in the responses to the scenario the participants were engaged in discussing. This was in tension with the humanitarian rationality that was at work. This is not to say that the economic rationality does not have its own values underpinning it, for indeed it does. These values, however, are in tension with the humanitarian values and could be considered to be antithetical to the project of fostering a global public health ethic (Benatar, Gill, and Bakker 2009; Gill and Bakker 2011).

Quid Pro Quo

The initial scenario with which participants were presented was met with a sense of indignation across the three town hall meetings we held. As described in the case, Indonesia's threat to withhold virus samples and refrain from animal culls was thought to be an unscrupulous act:

> I see what they're doing is they're saying, "We're going to hold the whole world hostage unless you pay for everything and any of our perceived losses." … They're holding the rest of the globe hostage and [the rest of the world] will say, "We will isolate and quarantine that power."

In response to this, there was very little will to come to Indonesia's aid, with one participant saying, "Keep your virus, keep your disease, keep your deaths, keep your illness." While in the minority, there were a few participants who felt that this was not the appropriate response:

> I would personally state that to help protect the citizenry as well as the public surrounding [Indonesia], that from a regional, national, local, and global perspective, that we do go in and assist to help maintain the human population as best possible.

The dominant sentiment however was that if Indonesia were to share virus samples and comply with animal culling practices to curb contagion, then Canada would be able to come to its aid. This was very much a "tit for tat" rationale for providing assistance: "It would be ethically right for Canada to say, 'If you give this, then we can look at giving you that.'" Any assistance that Canada might offer was contingent upon Indonesians sharing the virus sample.

Self-Interest

Once the scenario shifted and Canada was being asked formally to donate 10 percent of its stockpile of antiviral drugs to help contain the spread of the virus, participants began to consider whether or not this was in Canada's best interests:

> [B]y helping those countries, we're helping ourselves, because if we don't help those countries and this thing does become a global pandemic, those countries who may have had access to resources in developing a vaccine, they may say, "You didn't help us in our time of need, therefore we will not help you in your time of need."

This response blends both the sense of aid being contingent upon giving something in exchange and the notion that aid can be justified based upon a country's self-interest. Another participant rationalized providing antivirals to other countries in order to contain the outbreak but was not willing to do anything to address any economic consequences a country might suffer as a result of a travel or trade ban:

> I just don't want them spreading the virus from one country to another to the point where we can't control it. So control their problem, save their people, but in terms of their economics, that's their problem.

Once the scenario posited an influenza outbreak in Canada, the interests of other countries became far less important to some participants:

> When it gets here, all bets are off. You are focusing on limiting the spread within your own country. You are sharing the information out, but no longer your supplies or things. … I mean, it's nice to sit there and say, "I'm a global, I'm hugging trees so much" … the reality is you've got to be practical.

It is interesting to note that this is not framed as an obligation to one's own citizens but as just being "practical."

Cost-Effectiveness

Much of the morning discussion centered on identifying and weighing what the costs and benefits might be for Canada with regard to donating 10 percent of its stockpile and, alternatively, what the costs and benefits of doing nothing might be. Often, this discussion was framed as an issue of getting a good return on the investment:

> But what are you going to get … are you going to rebuild that 10 percent of the supply that you just used to stop it? Or are you going to get 5 percent back for the 10 percent you spent, or are you going to get 30 percent for the 10 percent you spent? I guess that's the big question … what's your buy back? Is your initial spending worth the investment?

Another concern about providing aid to Indonesia was whether it would be effective. These concerns centered on a sense of futility in donating antivirals because of what were perceived to be intractable problems that would not be solved by doing so. Such problems were perceived to relate to the lifestyle of Indonesians "who live with their chickens" but also the assumed corruption in the governance of poorer countries:

> The difficulty in this foreign aid that's been going on is the supplies … it comes into the country and 60–70 percent of it is hijacked and sold off of the back door to buy weapons or to line someone's pockets. I think there needs to be monitoring to make sure it gets back to people.

Obviously, aid that never reaches its intended recipients would not be deemed an effective use of scarce resources. However, this response demonstrated a fairly common blanket assumption on the part of participants that a nation that is relatively poor is run by corrupt political systems. In addition, there were concerns raised over the capacity of poorer countries to have "educated" people in charge of medical resources to ensure that they are used correctly. It became an important part of the facilitators' job during these focus groups to provide accurate information upon which to base the deliberations, while not unduly influencing the course of the conversation.

Once the scenario shifted so that the outbreak originated in Canada, the participants' weighing of the costs and benefits of helping other countries ended. The dominant sentiment was that there were not enough resources to go around, and therefore Canada's obligation was to use its resources for its own people: "[Resources should be] all devoted internally. There is no point in sharing; we've got to fix our own problems, because we don't have enough for our own priorities, right?"

Incentives

As a way of incentivizing Indonesia to share the virus sample, it was suggested that less than the requested 10 percent of the antiviral stockpile be given:

> You want the aid to get to the people. So you provide the aid to the people through the politicians, but then you also tell the politicians that, had they cooperated and joined forces with you, that they could have saved twice as many people, perhaps, and they would have kept their offices for life because they would have looked like saviors, because they were doing something for the people.

This is in keeping with economic notions that incentives are what drive humans to behave in particular ways, except in this instance applied by the participant to the behavior of nation states and their rulers. This is in stark contrast to the notion of reciprocity that emerged in other parts of the dialogue.

Elements of a Humanitarian Rationality

Proximal Versus Distal Obligations

Although in the minority at the beginning of the day, there were participants who were less black and white about what Canada's obligations might be to its citizens

and to other countries. These participants were much more comfortable discussing "ethics" directly, in contrast to others who were more comfortable looking for pragmatic solutions that would circumvent engaging in moral discussions or looking for a means of allocating resources based upon epidemiological data or analyses of cost-effectiveness alone. Some participants felt quite strongly that Canada's moral obligations were to its own people first, especially to First Nations communities where suicide rates and poverty are an issue: "I'm saying it's like Canada going and saying to Indonesia, ' … [W]e're going to solve your problems when we can't even solve our problems at home yet.'"

However, some participants wrestled with the problem of whose needs should trump whose and what the state's obligations might be to meet the health needs of people around the globe:

> I believe in protecting human life. I think it's very important, but then … the ethical question becomes somewhat more gray. When do I protect life in the Third World, if it means my children are going to die at home? Then it becomes a much more gray area. … [E]thical choice becomes much more difficult and I don't have the answers to that.

Implicit in this kind of thinking was the notion that there might be additional reasons for helping others that did not involve self-interest, even of the enlightened sort. Furthermore, the moral ambiguity expressed here contrasts with the certainty expressed by participants using an economic rationality to inform their decisions.

Empathy

There was evidence that some participants thought the version of morality instantiated in quid pro quo thinking that had dominated the morning sessions was deficient. Some participants, although they were in the minority, had asked from the beginning for a compassionate response to the Indonesian position:

> My Dad had a bumper sticker on his travel trailer that said: I complained that I had no shoes until I met a man who had no feet. … I can understand [Indonesia's] resistance to helping other countries because they have been left to their own demise. … [I]f we can put ourselves into their perspective, in their shoes, understand their issues that they're dealing with, with respect to protecting their population before looking at the global population …

Ironically, this person was asking for understanding of a position that others later adopted themselves when it came to Canada putting the needs of its citizens first. Beyond this, however, there was an understanding on the part of some participants that their position in Canada was very much more privileged than that of others: "I get up and I wonder, 'Gee, do I have time to go fishing today?' And these people get up and wonder, 'Am I going to have enough to eat today to live to see tomorrow?'"

There was widespread acknowledgment in the afternoon sessions that other countries might have different health priorities from Canada:

> So you know, we have our own health challenges with childhood fatality, dengue fever, Chagas [disease]. You and the rest of the world are worried about a pandemic, but that's your problem. … Whose priority counts?

The question of whose priority counts is a profound one for global health, the posing of which can only come once there is an acknowledgment that people living in other countries may have equally, or even more pressing, moral claims to health resources.

Reciprocity

When the conversation turned to talk of an outbreak that started in Canada as part of Reveal Two in the scenario, memories of Toronto's experience with SARS began to come to mind for the participants. Awareness of economic damage Toronto had suffered as a result of the outbreak and the subsequent WHO travel advisory led participants to consider that other countries might have a responsibility to support countries that have had travel bans or advisories placed against them:

> I think under our aid policies, [Canada] should consider [that responsibility to support], because much of Toronto was hugely affected, their economy was hugely affected by the SARS thing, and people lost their jobs and all sorts because the businesses could not continue. Indonesia is not that well off a country, and there is going to be a lot of businesses that fold.

Once the scenario changed and the outbreak originated in Canada, more participants began to develop a

notion that there might be reciprocal obligations between countries, and Indonesia's stance on withholding the virus came to be viewed by some as a response to global inequities in health:

> I can understand the resistance to helping other countries because they have been left to their own demise, and many of those countries that we have seen with the high mortality rates … who's jumping in right now to help that country out? So I can understand the perspectives of saying we're holding this information back because we don't want to be exploited again, as one of the forgotten few, when the rest of the Western developed world benefits from our demise.

In keeping with the insights of other participants already presented, one participant acknowledged that, for poor countries, health priorities may not align with Canadian ones:

> The Indonesian citizen, you know what they're going to say? "Vaccine? I don't even have a *meal* for this afternoon! … I don't care if I die from that because I'm so hungry, I'd rather be dead." That's the Indonesian.

Despite the fact that there was a fallacious assumption at work here that all Indonesians live in poverty, which is not as true for this country as it may be for some others, the acknowledgment that there may be other, more pressing issues raises the question of how richer countries can oblige poorer countries to adopt their health priorities without some form of reciprocal obligation taking hold. In response to a participant who said that poorer countries that are asking for something from richer countries need to commit to following "scientifically proven methods" to improve population health, another participant said: "As long as the rest of us are going to help them do that. There has to be the balance between their willingness to implement it and our willingness to help them." In contrast to a strict quid pro quo notion of how aid might work, it was suggested that fulfilling obligations to other countries to prevent the spread of an infectious disease might invoke reciprocal obligations in countries that benefit from these acts:

> Indonesia [is] sort of on the poorer scale, but it's not as poor as other countries, like Ethiopia for example, but somewhere in that spectrum. If it falls into the realm of a country that needs Canada's aid, is the fact that they're culling and being good global countries, global citizens … thinking of the greater good of the world, does that push them up on the aid criteria for us?

Here, rather than being transactional in nature, aid would be predicated on fulfilling moral obligations.

There was a developing sense that Canada has obligations to provide aid to countries who take responsibility for reducing the conditions that lead to influenza pandemics and for improving surveillance capacity and transparency about outbreaks, but there also was a sense that countries whom we aid in these endeavors have reciprocal obligations to ensure that aid is not diverted: "I think that if we're going to provide that compensation, we have to be able to ensure that it gets to where it's needed, as opposed to where it's not." Another participant said that aid "has to be coordinated from the big-picture down to helping the person in the community." This was presented as a condition of giving aid, as opposed to earlier in the day when corruption and a lack of capacity to deal with aid appropriately was presented as a reason not to give aid at all.

Trust and Transparency

Participants also recognized the importance of trust and transparency in the context of global pandemic governance. One participant wondered if there was a lack of trust that explained Indonesia's reluctance to part with biological information that could lead to the development of a vaccine:

> It sounds like we're talking global politics and the trust issues. So there almost needs to be a mediator and a negotiator to try and move it forward past those trust issues. I don't know how we go about that.

The International Health Regulations developed by the World Health Organization require countries to report infectious disease outbreaks that are of potential international significance, and this is deemed important not only to outbreak response but also to trust within and between nations (World Health Organization 2008). However, participants were aware that this duty to report might come at a cost to the nation reporting the outbreak because of their awareness of what happened in Toronto during the SARS outbreak. One participant identified a

reciprocal need for trust on the part of the reporting country:

> [T]rust [is] foundational, so that if Indonesia reported to the World Health Organization, it would be done in an envelope of trust, that I'm telling you this, but you're not necessarily going to broadcast to the world that there's a suspicion of something going on until you're a little more sure that it is.

This demonstrated an understanding of the importance of the trustworthiness of the WHO in the management of pandemics, particularly when it comes to mandatory reporting requirements. There seemed to be consensus, however, that transparency was important in pandemics:

> It's a bigger picture than just one city. It's got to be realized and if [Canada] happened to be ground zero for the pandemic outbreak, then you've got to let other people know, you can't just hide it and hope that somebody else figures it out and deals with the problem. It's not one of those problems you can sweep under the rug.

The acknowledgment demonstrated in this quote—that pandemics unite us in our vulnerability—was echoed by many other participants.

Solidarity

The aforementioned acknowledgment that other countries might have other health priorities was important because this is perhaps the first step in developing a sense of solidarity. The notion of solidarity developed through the course of the day in all three town hall meetings. Eventually, this feeling of solidarity evolved from a sense of common purpose in addressing an influenza pandemic to solidarity with the *people* of other countries:

> At the end of the day, when you strip it all down, when you strip away all the social dispositions that we have and all the social constructs that we have, we're all human and we all have … the moral consciousness of looking after each and every person in this world regardless of social disposition or wealth or, you know, access to medications or antivirals or any sort of viruses that we need to develop into something that's going to become medicine. … [W]e're all human at the end of the day, and I think it's something that gets lost repeatedly amongst political leadership.

A discussion about the limits of providing support to poorer nations (aid versus "paying the entire bill") elicited the response from one participant: "I'm still a human, so we have to look after those who are more disadvantaged than ourselves." The sense that a collaborative approach was essential emerged: "We've got to start collaborating with these people … to try and break down those fortresses." It was important to some participants that poorer countries be included in pandemic planning to avoid the kind of paternalism that can often happen in the giving of aid to foreign countries:

> Be more inclusive. Bring them straight in there and get the grass roots approach, rather than ignoring or saying we know what's best for you. Let them come and share their experiences with us. So again, work as a collective, for the development of all people.

Ultimately, this sense of solidarity gave rise to the articulation of an ethical duty to address global health disparities:

> I do think that we as Canadians are very fortunate. … I do think that we have a moral obligation to try to raise, and I'm not saying that you can fix everything in the world, we have to be realistic, but we do have a moral obligation to try to raise the standard of people in other parts of this world.

Over the course of the day, then, there was a shift in participants' moral sentiments in response not only to the changes in the scenario as it unfolded but also to the deliberations that were occurring between participants. The initial scenario elicited "top of the head" responses, while subsequent discourse was better informed and considered. Over the course of the day, there was an overall shift in moral sentiments away from the initial indignation felt by participants at Indonesia withholding virus samples toward a sense of compassion and solidarity.

Discussion

Economics constrains our thinking about health in the West and, in turn, how we view (or fail to view)

normative concerns to a very great extent. Put another way, economic notions permeate Western society's collective consciousness about health. Even within bioethics, discourses of justice are often narrowly constrained to issues of the fair distribution of resources (Powers and Faden 2008). While the fair distribution of resources is certainly relevant to global health ethics, other relevant notions of justice, such as compensatory justice, receive far less attention.

The reluctance of some participants to engage in moral discourse around the issues raised by this provocative scenario is not unusual in our many years of experience conducting qualitative research on questions of an ethical nature. The amount of time devoted to finding practical solutions that would circumvent having to engage with the thorny moral questions about the limits of a state's sovereignty, what its obligations are to its citizens and to the global community, and what is owed to one another was significant. By contrast, people were more at ease with a discourse that invoked economic notions and were much more willing to make declarations with certainty when invoking them. When a humanitarian rationality was invoked, participants often expressed confusion over what ought to be done and presented solutions more tentatively.

Ironically, those who viewed Indonesia's actions as selfish and condemned the country for acting out of self-interest failed to see the parallels between what Indonesia did and their own stance on the prioritization of Canadian lives over others. While they argued that Canada has an obligation to protect and promote the health of Canadians, they did not view Indonesia's actions as the act of a sovereign nation protecting its citizens. Their own desire to get something in return for providing aid was deemed appropriate, whereas in Indonesia's case the same desire was viewed as indicative of a "hostage" situation. In contrast to this, those who were empathetic were able to see that Indonesia, as a country of lesser means, had little recourse other than to leverage its biological capital to get what it needed.

Participants who preferred to weigh costs and benefits rather than the moral trade-offs again demonstrated the way that economics has penetrated the lay imagination. The desire to ensure that aid was effective was driven not by a moral imperative to address a pressing human need but to ensure that resources were not being squandered. While this is certainly a part of good stewardship, it precludes a discussion around the issue that other countries may have a moral claim on global health resources. In this way, then, it narrows the discourse to exclude a broader conversation of other ethical considerations. This mirrors health policy discourse around cost-effectiveness or cost-benefit analyses (Powers and Faden 2008) and broader policy where ethical, social, and cultural issues are put into a "techno-bureaucratic box" (Garoon and Duggan 2008) and subjugated to the dominant discourse of economics.

In their critical discourse analysis of 37 national pandemic influenza plans, Garoon and Duggan (2008) show that a tacit economic reductionism is driving not only the goals of pandemic planning but also the proposed response. The preservation of social order and functioning is a self-evident goal, despite the fact that preserving social order and functioning entails maintaining health inequities and patterns of disadvantage (Garoon and Duggan 2008). So much of our discourse around health is permeated with economic discourse, where efficiency has become a "cult" (Stein 2002), health disparities are viewed as natural rather than the result of economic power relations, and modern advances in health are driven by market forces rather than human need (Benatar, Gill, and Bakker 2009). This is not to say that economic concerns are not morally relevant, for indeed quite the opposite is true. However, orthodox economics has given rise to what Gill and Bakker (2011) call a "market civilization" that is individualistic, consumerist, and privatized, among other things. Despite the fact that there are many other ways to think about economic theory, self-interest has remained central to much of economic theory, despite empirical evidence that agents are not just activated by self-interest (Sen 1977). The resulting valorization of acting on self-interest over solidarity is reflected in these data. Indeed we saw this when one participant took it as self-evident that if Canada was the source of the outbreak, supplies would go to its citizens, and this was framed as being "practical." That this person deems it impractical to share resources during a pandemic of local origin demonstrates how acting in self-interest has become common sense, or the "rational" response.

The humanitarian values of trust, transparency, solidarity, and reciprocity that emerged from these focus groups are reflected in many ethical frameworks dealing with planning for infectious disease outbreaks. In particular, the ethical framework developed by the University of Toronto Joint Centre for Bioethics contains these values, among others (University of Toronto Joint Centre for Bioethics Pandemic Influenza Working

Group 2005). While this framework was the result of both conceptual scholarship and a prolonged stakeholder vetting process with health care workers and many levels of government decision-makers, it did not include members of the public (Thompson et al. 2006). It is interesting to note, then, that these values seem to have resonance across lay and expert populations, and these findings speak to the robustness of earlier work on ethical issues in pandemic planning, going back to the SARS outbreak in 2002–2003 (Singer et al. 2003).

Values underpinning some of the issues raised in the data that we have categorized as part of the "economic rationality" are also echoed in other ethical guidance documents around infectious diseases. For example, the WHO's ethical guidance document on the control and care of tuberculosis includes the value of "effectiveness" (World Health Organization 2010). While the latter is framed slightly differently than the cost-effectiveness discussed by participants, the underlying value of good stewardship over scarce resources is shared. Thus, it must be stated that the economic rationality is not value-free and therefore does not represent an extra-moral discourse. The problem lies in the narrowing of relevant concerns within the economic rationality, where the value of "effectiveness" becomes limited to issues of "cost-effectiveness," and concerns about how one determines what is most morally significant to "effectiveness" (for example, does a treatment save lives?) become subjugated to issues of "bang for the buck" (are costs to the health care system lessened?). While sometimes what is a morally effective option is also the cost-effective option, too often this is not the case, and the preoccupation with cost-effectiveness directs our attention away from social inequalities in health (Powers and Faden 2000; Thompson 2013).

However, a day-long engagement process where people are asked to provide public reasons and to deliberate the ethical issues raised by the scenario allowed participants to develop their moral imaginations and begin to transcend the limitations of the tacit economic rationality that so many of them brought to the table. When we speak of moral imagination, we refer to Jonathan Glover's (2000) notion that the moral imagination is the ability to put oneself in the shoes of another. While we would not argue that these town hall meetings were "ideal speech" situations (Habermas 1970), we were encouraged that this kind of public engagement could elicit such a shift in the participants' moral sentiments. Shifts in attitudes and opinions are common in focus groups (Kitzinger 1994); however, the shift toward a more compassionate view of the Indonesian position was not a foregone conclusion. While some participants came into the day already able to imagine themselves in the shoes of others, others were able to eventually discern that there were humanitarian reasons for action. This happened when participants engaged emotionally with situations in a manner that negated self-interest and allowed them to demonstrate empathy, compassion, and solidarity. The willingness of some participants to frame the issues presented in the scenario as a matter of balancing distal and proximal obligations to others, instead of insisting on a stance that furthered domestic interests as a matter of "practicality," demonstrates this. This is the first step in shifting public discourse about global relations from one where nations continue to view themselves and the health of their citizens in isolation. Only in this way can we challenge the view that so many in these town hall meetings espoused early on in the day, that poverty is the result of bad government and has nothing to do with the power of wealthy nations. While corruption is part of the explanation, "wealthy nations, and by association their citizens, are deeply implicated in the generation and maintenance of forces that perpetuate social injustice and poverty" (Benatar 2005, 1209). While it would be overstating things to say that the participants came to this particular realization, we should not underestimate the importance of the participants' shift toward a sense of solidarity that was facilitated by participation in a deliberative process.

The use of an evolving scenario to elicit participants' moral responses to a hypothetical pandemic influenza outbreak allowed us to use focus group methodology to its best effect.

While the focus of this inquiry was not the procedural aspects of the methodology, but rather the content of the discussions, it is worth noting the moral significance of the shift toward a humanitarian rationality that took place over the course of the day. Shifts are to be expected as people's attitudes and opinions are "constructed through discussion and interaction" (Millward 2012, 415), and this process of the co-creation of meaning and reality within the focus group setting has been studied in its own right (Catterall and Maclaran 1997). The promise of this methodology to foster the development of moral imagination through the use of staged scenarios and group deliberation warrants further research. If we consider the development of our

collective moral imagination as one of the grand challenges for global health, as Benatar (2005) urges us to do, it is possible that we have identified an important methodology for public engagement that has the potential to encourage people to frame issues of global health in moral rather than economic terms and through deliberation foster the values of empathy, solidarity, and reciprocity that are essential if we are to address global health inequities. For while we may be entering a new era of collaboration and cooperation in global health governance (Santos-Preciado et al. 2009), it will be not be sustainable if we cannot find ways of fostering the moral sentiments of compassion, solidarity, and "mutual caring" (Benatar, Daar, and Singer 2003) in our citizens.

Appendix 1: Global Governance Scenario With Facilitator Questions

Participants were asked to consider the following scenario in stages, without reading ahead to the next "reveal." It was not until the afternoon sessions that participants were asked to consider Reveal Two.

Primer

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

Initial Scenario: Pre-Pandemic Preparedness

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

First Set of Questions

1. What are your initial responses to this situation? (What is your gut reaction?)
2. What are the most important considerations in this scenario?
3. What are the features of this situation that you find the most compelling?
4. Based on your discussion thus far, how should Canada respond to:

   a) Indonesia's demands for more equal access?
   b) The developing world's (poorer countries') demands for fairer public health investment assistance more generally?

Reveal One: Initial Confirmed Emergence of a Pandemic Influenza Strain in Rural Southeast Asia

The World Health Organization (WHO) tests some samples from rural Indonesia and confirms the emergence of highly transmissible human influenza. Influenza is highly transmissible and limiting travel may be effective in delaying the spread of the disease, although this remains uncertain. In addition, there is some evidence to suggest

that if all countries share their antiviral stockpiles, the magnitude of the outbreak could be reduced.

Second Set of Questions

5. Have your initial responses to the situation changed in light of this information?
6. Are there any facts that you find significant in this latest piece of information?
7. Is there anything compelling about this development?
8. Based on your discussion thus far, how should Canada respond to:

    a) The reduction or stopping of travel to and from Indonesia? (Probe for economic costs/compensation and whether it will be fair to the Indonesians/Canadians.)
    b) A request from WHO to release 10 percent of national stockpiles to contain the outbreak in Indonesia?

Reveal Two: Initial Confirmed Emergence of Pandemic Influenza Strain in Canada

Imagine the outbreak initially started in Canada, where the World Health Organization (WHO) tests some samples from Winnipeg and Toronto and confirms the emergence of highly transmissible human influenza.

Third Set of Questions

9. Have your responses to the situation changed in light of this information?
10. Are there any facts that you find significant in this latest piece of information?
11. Is there anything compelling about this development?

    a) Does your perspective on this case and on appropriate travel restrictions, international resource sharing, and compensation change when a pandemic emerges here and threatens to spread internationally, rather than the other way around?

12. Based on your discussion thus far:

    a) Should Canada be under obligation to report/share information with the international community even if it impacts the economy?
    b) Should there be a travel advisory to and from Canada?
    c) Whom do you think should be primarily responsible for determining how the pandemic in Canada should be managed? (Probe for WHO, provincial government, federal officials—and also probe for reasons why.)

Final Questions

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

References

Benatar, S.R. 2005. Moral imagination: The missing component in global health. *PLoS Medicine* 2(12): e400. doi:10.1371/journal.pmed.0020400.

Benatar, S., A.S. Daar, and P.A. Singer. 2003. Global health ethics: The rationale for mutual caring. *International Affairs* 79(1): 107–138.

Benatar, S., S. Gill, and I. Bakker. 2009. Making progress in global health: The need for new paradigms. *International Affairs* 85(2): 347–372.

Bensimon, C., M. Smith, D. Pisartchik, S. Sahni, and R. Upshur. 2012. The duty to care in an influenza pandemic: A qualitative study of Canadian public perspectives. *Social Science and Medicine* 75(12): 2425–2430.

Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, and Social Sciences and Humanities Research Council of Canada. 2010. Tri-council policy statement: Ethical conduct for research involving humans. Her Majesty the Queen in Right of Canada. www.pre.ethics.gc.ca/pdf/eng/tcps2/TCPS_2_FINAL_Web.pdf. Accessed November 12, 2013.

Catterall, M., and P. Maclaran. 1997. Focus group data and qualitative analysis programs: Coding the moving picture as well as the snapshots. *Sociological Research Online* 2(1). www.socresonline.org.uk/2/1/6.html. Accessed November 15, 2013.

Garoon, J.P., and P.S. Duggan. 2008. Discourses of disease, discourses of disadvantage: A critical analysis of national influenza preparedness plans. *Social Science and Medicine* 67(7): 1133–1142.

Gill, S., and I. Bakker. 2011. The global crisis and global health. In *Global health and global health ethics*, edited by S. Benatar and G. Brock, 221–238. New York: Cambridge University Press.

Glover, J. 2000. *Humanity: A moral history of the twentieth century*. New Haven, CT: Yale University Press.

Guba, E., and Y. Lincoln. 2005. Paradigmatic controversies, contradictions, and emerging confluences. In *Handbook of qualitative research*, 3rd ed., edited by N.K. Denzin and Y. Lincoln, 191–216. Newbury Park, CA: Sage Publications.

Habermas, J. 1970. Towards a theory of communicative competence. *Inquiry* 13(1–4): 360–375.

Kitzinger, J. 1994. The methodology of focus groups: The importance of interaction between research participants. *Sociology of Health and Illness* 16(1): 103–121.

Labonte, R., T. Schrecker, and A. Sen Gupta. 2005. *Health for some: Death, disease and disparity in a globalizing era*. Toronto: Centre for Social Justice.

The Lancet. 2007. Global solidarity needed in preparing for pandemic influenza. *The Lancet* 369(9561): 532.

Lincoln, Y.S., and E.G. Guba. 1985. *Naturalistic inquiry*. Thousand Oaks, CA: Sage Publications.

McDougall, C., R. Upshur, and K. Wilson. 2008. Emerging norms for the control of emerging epidemics. *Bulletin of the World Health Organization* 86(8): 643–645.

McDougall, C., and K. Wilson. 2007. Canada's obligations to global public health security under the revised international health regulations. *Health Law Review* 16(1): 25–32.

Millward, L. 2012. Focus groups. In *Research methods in psychology*, 4th ed., edited by G.M. Breakwell, J.A. Smith, and D.B. Wright, 411–437. London: SAGE Publications.

Morgan, D.L. 2010. Reconsidering the role of interaction in analyzing and reporting focus groups. *Qualitative Health Research* 20(5): 718–722.

Powers, M., and R. Faden. 2008. *Social justice: The moral foundations of public health and health policy*. Oxford and New York: Oxford University Press.

Powers, M., and R. Faden. 2000. Inequalities in health, inequalities in health care: Four generations of discussion about justice and cost-effectiveness analysis. *Kennedy Institute of Ethics Journal* 10(2): 109–127.

Santos-Preciado, J., C. Franco-Paredes, I. Hernandez-Flores, I. Tellez, C. Del Rio, and R. Tapia-Conyer. 2009. What have we learned from the novel influenza A (H1N1) pandemic in 2009 for strengthening pandemic influenza preparedness? *Archives of Medical Research* 40(8): 673–676.

Sen, A.K. 1977. Rational fools: A critique of the behavioral foundations of economic theory. *Philosophy and Public Affairs* 6(4): 317–344.

Silva, D., J. Gibson, A. Robertson, et al. 2012. Priority setting of ICU resources in an influenza pandemic: A qualitative study of the Canadian public's perspectives. *BMC Public Health* 12(1): 241.

Singer, P., S. Benatar, M. Bernstein, et al. 2003. Ethics and SARS: Lessons from Toronto. *British Medical Journal* 327(7427): 1342–1344.

Smith, M., C. Bensimon, D. Perez, S. Sahni, and R. Upshur. 2012. Restrictive measures in an influenza pandemic: A qualitative study of public perspectives. *Canadian Journal of Public Health* 103(5): e348–e352.

Stein, J.G. 2002. *The cult of efficiency*. Toronto: Anansi Press.

Thompson, A. 2013. Human papilloma virus, vaccination and social justice: An analysis of a Canadian school-based vaccine program. *Public Health Ethics* 6(1): 11–20.

Thompson, A., K. Faith, J. Gibson, and R. Upshur. 2006. Pandemic influenza preparedness: An ethical framework to guide decision-making. *BMC Medical Ethics* 7(1): 12. doi: 10.1186/1472-6939-7-12.

University of Toronto Joint Centre for Bioethics Pandemic Influenza Working Group. 2005. *Stand on guard for thee: Ethical considerations in preparedness planning for pandemic influenza*. Toronto: University of Toronto.

World Health Organization. 2008. *Outbreak communications planning guide*. Geneva: World Health Organization, NLM: WA 110. http://www.who.int/ihr/elibrary/WHOOutbreakCommsPlanngGuide.pdf.

World Health Organization. 2010. *Guidance on ethics of tuberculosis prevention, care and control*. Geneva: World Health Organization, NLM: WF 200. http://whqlibdoc.who.int/publications/2010/9789241500531_eng.pdf.

Wilkinson, S. 1998. Focus group methodology: A review. *International Journal of Social Research Methodology* 1(3): 181–203.