Virtual Mentor
American Medical Association Journal of Ethics
June 2010, Volume 12, Number 6: 460-465.

JOURNAL DISCUSSION
Rethinking the Physician's Duty in Disaster Care
Douglas Bernstein, MD

Iserson KV, Heine CE, Larkin GL, Moskop JC, Baruch J, Aswegan AL. Fight or flight: the ethics of emergency physician disaster response. *Ann Emerg Med*. 2008;51(4):345-353.

Moskop JC, Iserson KV. Triage in medicine, part II: underlying values and principles. *Ann Emerg Med*. 2007;49(3):282-287.

Government plans for natural and man-made disasters generally presume the full-fledged participation of the medical community, but that presumption may not be reasonable or reflect the real-life decisions and actions of emergency personnel in a crisis [1]. Two notable articles by Iserson, Moskop, and colleagues present commonly used ethical principles and give specific examples to lead readers to reflect on their own values regarding the balance of personal safety and the duty to care for patients.

"Fight or Flight: The Ethics of Emergency Physician Disaster Response," by Iserson et al., examines both the theoretical and the practical behaviors of medical staff during epidemics and natural and man-made disasters. The piece considers two related questions: *should* health care professionals stay during a disaster, and *are they likely to*? The authors consider recent events in the context of fundamental ethical principles and advocate that medical personnel familiarize themselves with these principles *before* they are called upon to respond to a disaster.

The article begins with a historical perspective, suggesting that although individual doctors can be fickle in the face of danger, physicians in general tend to stay and treat patients despite personal risks. The reasons for this selfless behavior are many; the authors specifically mention "the great needs of patients, the special expertise of health care professionals, the professional duty of beneficence, the special societal support given to health care professionals, and the duty to accept a fair share of workplace risks" [2].

They give two main reasons why health care workers might not report for duty: the understandable conflict of interest between treating patients and caring for one's family, and the right to protect oneself from grave risks. If a virulent epidemic were both highly lethal and easily transmissible, for instance, might the situation justify fleeing? For health workers to find a reasonable balance between risk and duty requires effective communication about the nature of the crisis, and the authors move

beyond hypothetical premises by suggesting specific communication strategies to minimize panic and to encourage worker participation during the initial fear and confusion. In the end, of course, the decision to stay and work is deeply personal, and the authors concede that "there appears to be no uncontroversial way to establish a threshold at which risk acceptance becomes a duty" [2].

The paper neglects some justifiable reasons that health workers may avoid disaster duty. The utilitarian appeal for doctors to do the "greatest good" should be considered. An emergency physician can be expected to treat far fewer patients during the crisis (even assuming herculean efforts for a weeklong disaster) than in a normal working year, let alone an entire career. If a physician is disabled or killed in the line of duty, the loss to society—measured in terms of total patients treated—may not be justified.

There is a more fundamental question here, one that is glossed over by the assumption that the doctor's goal will be to maximize his or her contribution, that needs asking: are doctors necessarily obligated to contribute at all? The assertion that "physicians may fear the shame or social ostracism that results from abandoning patients" [2] implies that a patient-doctor relationship has been established. This implication is subtle but important: are all *people* in a disaster situation automatically *patients*? The answer by necessity is no; a pre-emptive establishment of duty on behalf of a group of people cannot simply be imposed or assumed, and the duty to care must be recognized voluntarily by the physician.

Certain emergency situations preclude the physician's free choice [3]. As a hypothetical example, a lone physician on a remote island is ethically obligated to care for a patient with a true medical emergency. The obligation in this example is derived from four factors, which include the patient's *degree of need*, the physician's *proximity* to the patient, the physician's *capabilities*, and the *absence of other sources of aid* [4]. An 80-year-old retired dermatologist is not as obligated to respond to a crisis as a 35-year-old emergency medicine specialist. Similarly, a doctor in Manhattan does not have the same ethical obligation to respond to an earthquake in Haiti as to one in Brooklyn. The paper by Iserson et al. fails to explicitly identify any of these factors, which may leave readers confused about where duty begins and ends. The authors also neglect to make the distinction between current and future patients; certainly, a physician is not equally obligated to respond to a situation in which a patient is *likely* to appear as in a situation in which a patient has *already* appeared [5].

Concerns about duty are not merely theoretical. The establishment of duty features prominently in medical malpractice law. The authors assert that fear of legal repercussions are "unfounded or highly exaggerated" and that "health care professionals who are asked to assume new tasks during a disaster will not be required to demonstrate the same level of expertise as would be expected in normal circumstances" [6]. The medical and legal literature on this issue, however, do not necessarily support this conclusion. An article in *Public Health Reports* finds that in

"extraordinary circumstances, the provider is exposed to greater liability simply because his or her care may have to be greater as the situation demands. Understandably, before undertaking to aid a victim during a public emergency, the responder may want greater assurance of liability protection" [7]. These authors conclude that only one-third of U.S. states have enacted prospective immunity protections for emergency workers, and even those are based on Good Samaritan statutes that likely would not apply to paid physicians working in a hospital setting [7-9].

A telling example of a responder incurring liability during a disaster is the case of Dr. Anna Pou, a surgeon who stayed to treat patients during Hurricane Katrina. Unable to evacuate a group of patients too sick or large to move, Pou injected some of them with a potentially lethal combination of sedatives and painkillers, and they died. She was later charged with four counts of second-degree murder, and, though a grand jury did not indict her, Dr. Pou is still battling multiple wrongful death civil suits for her actions [10]. Although legal concerns in emergency situation may be exaggerated, having reached the point at which a doctor responding during an epic natural disaster can be tried for *murder*, such concerns are certainly reasonable and should be considered an element of the "risk equation" for emergency responders.

Another case from Hurricane Katrina highlights the complex moral considerations of patient care during disasters. Althea LaCoste was a 73-year-old woman dependent on a mechanical ventilator at the time of the hurricane. When the hospital's back-up electricity failed, nurses manually ventilated her for 15 hours, in sweltering darkness, before she succumbed to her multiple illnesses. Her family subsequently sued the hospital for negligence. Though the hospital's lawyer argued that in the LaCoste family's "moment of most desperate need, we did not turn our backs on them when the hurricane had them and us in its sights," the case was settled for an undisclosed sum of money [11, 12].

While this case raises the question of how much care for the individual patient is *enough* (to avoid liability or to fulfill one's putative duty), it also informs the opposite—public health—perspective: should Ms. LaCoste have received *less* care? During those initial 15 hours, how else could that precious resource—nursing expertise—have been utilized? What if the nurses' attention to other more salvageable patients had saved a life? What about ten other lives? And more fundamentally, what is the moral significance of even asking such questions?

Such thorny issues are the topic of another article by Dr. Iserson and John Moskop, titled "Triage in Medicine, Part II: Underlying Values and Principles" [13]. The authors analyze various justifications for triage systems through the lens of distributive justice, a philosophical concept that addresses the fair allocation of benefits and burdens within society. Various ethical principles are examined, each of which validates triage systems from a different perspective. The issues that arise about the moral consequence of triage are powerful, even disturbing. Readers may begin to question how the Hippocratic Oath changes in the setting of scarce

resources, and how health workers can honor and respect patients while withholding treatment from them.

Utility is one of the fundamental principles of distributive justice. Often summarized as the "greatest good for the most people," it emphasizes the *net* effect on a population. According to this principle, it is acceptable that medical resources be deliberately withheld from some patients (risking a bad outcome for these individuals) if the overall net benefit to society (the number of other lives that can be saved with those resources) is greater. This principle is central to many disaster triage plans. Because utilitarianism directs that the outcomes for future patients be considered, an interesting (and controversial) consequence of this principle is the idea that, during a disaster response, emergency health workers and government officials may receive priority treatment, since they theoretically act as "multipliers" of societal benefit during and after the crisis [14].

In direct contrast, the principle of *equal chances* begins with the belief that every human life is equally valuable. The logical triage system that arises from this principle is first-come, first-serve, and does not assign priority to patients based on severity of injury, likelihood of survival, projected resource use, or the patient's possible future value and utility. A triage system based on the principle of equal chances is more "fair" to any given individual, but such a system can be expected to save fewer overall numbers of patients, and is not commonly found in modern disaster triage plans such as the widely-known Simple Triage And Rapid Treatment (START) protocol [15]. Finally, the article calls upon implicit and explicit social values to identify a variety of traits that define an effective triage officer, including decisiveness, knowledge about anticipated casualties, and creative problem-solving ability [16].

Of course, such traits are meaningless if health workers, who will be among those at highest risk during a mass disaster, do not show up to treat the wounded. Reading these two articles in tandem can empower emergency personnel with the ethical and social insights to make an informed assessment of their personal values. Because choosing to respond is deeply personal, and influenced by internal and external factors, such insights will be invaluable when future events force the decision: will I flee, or will I fight?

References

1. Inglesby TV, Grossman R, O'Toole T. A plague on your city: observations from TOPOFF. *Clin Infect Dis*. 2001;32(3):436-445.
2. Iserson KV, Heine CE, Larkin GL, Moskop JC, Baruch J, Aswegan AL. Fight or flight: the ethics of emergency physician disaster response. *Ann Emerg Med*. 2008;51(4):345-353.
3. American Medical Association. Opinion 9.067 Physician Obligation in Disaster Preparedness and Response. *Code of Medical Ethics*. Chicago, IL: American Medical Association; 2008-2009. http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-

ethics/opinion9067.shtml. Accessed May 18, 2010.
4. American Medical Association Council on Ethical and Judicial Affairs. Physician obligation in disaster preparedness and response. http://www.ama-assn.org/ama1/pub/upload/mm/code-medical-ethics/9067a.pdf. Accessed May 18, 2010.
5. Torda A. How far does a doctor's 'duty of care' go? *Intern Med J*. 2005;35(5):295-296.
6. Sokol DK. Virulent epidemics and scope of healthcare workers' duty of care. *Emerg Infect Dis*. 2006;12(8):1238-1241.
7. Rosenbaum S, Harty MB, Sheer J. State laws extending comprehensive legal liability protections for professional health-care volunteers during public health emergencies. *Public Health Rep*. 2008;123(2):238-241.
8. Immunity to Persons Giving First Aid from Damage Claim. Idaho Code §5-330(2006). http://www.legislature.idaho.gov/idstat/Title5/T5CH3SECT5-330.htm. Accessed May 18, 2010.
9. National Conference of Commissioners on Uniform State Laws. Uniform Emergency Volunteer Health Practitioners Act. http://www.uevhpa.org. Accessed May 17, 2010.
10. Fink S. The deadly choices at Memorial. *New York Times Magazine*. August 5, 2009. http://www.nytimes.com/2009/08/30/magazine/30doctors.html. Accessed May 17, 2010.
11. Kunzelman M. Trial opens in Katrina hospital death case. *Bioscience Technology*. January 12, 2010. http://www.biosciencetechnology.com/News/FeedsAP/2010/01/trial-opens-in-katrina-hospital-death-case. Accessed May 17, 2010.
12. Barrow B. Pendleton Memorial Methodist Hospital settlement leaves disaster-planning issues unresolved. *Times-Picayune*. January 26, 2010. http://www.nola.com/hurricane/index.ssf/2010/01/pendleton_memorial_methodist_h_3.html. Accessed May 17, 2010.
13. Moskop JC, Iserson KV. Triage in medicine, part II: underlying values and principles. *Ann Emerg Med*. 2007;49(3):282-287.
14. Iserson KV, Pesik N. Ethical resource distribution after biological, chemical, or radiological terrorism. *Cambridge Q Healthc Ethics*. 2003;12(4):455-465.
15. Super G. *START: A Triage Training Module*. Newport Beach, CA: Hoag Memorial Hospital Presbyterian; 1984.
16. Burkle FM, Sanner PH, Wolcott BW. *Disaster Medicine: Application for the Immediate Management and Triage of Civilian and Military Disaster Victims*. New Hyde Park, NY: Medical Examination Publishing Company; 1984.

Douglas Bernstein, MD, is a first-year resident in emergency medicine at the Yale-New Haven Hospital. He received his medical degree from the Johns Hopkins University School of Medicine and additional training in logistical planning and personnel safety for humanitarian aid missions at the Johns Hopkins Bloomberg School of Public Health. Dr. Bernstein completed an internship in general surgery at Duke University Medical Center before assuming his current residency position at

Yale. His research interests include medical ethics and resource utilization in the emergency department.

Related in VM
AMA *Code of Medical Ethics*' Opinion on Physician Duty to Treat, June 2010

The Ethics of Teamwork in Disaster Management, June 2010

Should I Stay or Should I Go? The Physician in Time of Crisis, April 2006

The viewpoints expressed on this site are those of the authors and do not necessarily reflect the views and policies of the AMA.

Copyright 2010 American Medical Association. All rights reserved.