Course Transcript for August 23, 2012, Day 1

Ethical and Legal Aspects of Disaster Response: Ethics and Disasters
Instructor: Patti Reynolds, MLS

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Presenter: Patricia Reynolds

We will start with ethics and disasters.

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Presenter: Patricia Reynolds

I started working on this topic about four years ago with the National Library of Medicine in a pilot project, which was embedded into our emergency management teams in our hospitals with a group of five people. First I am going to discuss ethics and disasters and to go into some definitions and we will make it interesting. Disasters and emergencies are international and local. They are multicultural, multiethnic, multi-religious, environmental, and man-made. They involve governments, NGOs, corporations, victims, workers, and the press. The ethical implications are at the core of everything in preparation, policies, response, and recovery. We are going to go into all of these aspects.

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Presenter: Patricia Reynolds

What is a disaster? These are my goals and questions I want to discuss as we go along. Why do we need to know the ethical basis of disaster preparation? What is special about a disaster that motivates people to act in certain ways and respond ethically? What are the relevant ethical principles that form the basis of our actions and reactions?

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Presenter: Patricia Reynolds

I want to pay attention and give a word of thanks to Naomi Zack at the University of Oregon who wrote the book Ethics for Disaster. It came out in 2009. It is a wonderful book; I highly recommend it. She gave us permission to post it in PDF format on Moodle.
I hate to read some of this because I know nobody likes to have somebody read slides but, these are very specific terms. "A disaster is an event that harms or kills a significant number of people or otherwise severely impairs or interrupts their daily lives in civil society. Disasters may be natural or the result of accidental or deliberate human action. They can include, but are not limited to, fires; as we know today out West, floods, storms, as we are watching the storm come up from the Caribbean here, earthquakes; chemical spills; leaks, or infiltration by toxic substances; terrorist attacks by conventional, nuclear, or biological weapons; epidemics; pandemics; mass failures in electronic communications; and other events that officials and experts designate as 'disasters.'

"Disasters are always occasion surprise and shock; they are unwanted by those affected by them, although not always unpredictable. Disasters always generate narratives and media representations of the heroism, failures and losses of those who are affected and respond."

I am sure you can all relate to those two paragraphs.

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Presenter: Patricia Reynolds

Emergencies are something else again. Emergencies are local and can be dealt with local resources. They are shorter in duration and a state of emergency is done for disasters, not emergencies. If you heard the news today I believe four counties in Northern California have been designated as emergencies because of the fires.

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Presenter: Patricia Reynolds

Let's get back to why we engage in disasters and why it is important for us. Dr. Zack said in her book that we are not going to talk about human conflict or, armed conflict of the disaster because they really generate different responses. In armed conflict people usually run away from it and the government is usually always involved.

In disasters we are drawn to it and we want to help people. We run to the disaster to see what we can do to help. It's a big difference in our sense of responses to what we can do.

In discussing these, we will discuss those disasters that are not involved with armed conflict and call on the very basis of our basic instincts that we have. We know our social contract with our government. "Government has an obligation, based on the justifications of its origins; to prepare

citizens for survival in second states of nature caused by disaster. Such preparation requires implementation through public policy." That was a statement by John Locke. These rights are presumed in the U.S. Declaration of Independence and protected by the first ten amendments of the Constitution. It is the basis of how we form our ethical attitudes towards our responses to disasters.

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Presenter: Patricia Reynolds

What is special about disasters that motivate people to act and respond ethically? Basic human values: compassion, empathy, respect for dignity of others, professional codes of conduct, and "there but for the grace of God, go I." We brought up the other day religious values as well. Are behind what motivates us to get involved and to help out.

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Presenter: Patricia Reynolds

Ethical theories and principles is not about what is but what should be. Ethical relativism is one ethical idea or principle that morality varies between people and societies according to the cultural norms.

The second principle is Universalist or objectivism moral theories: fundamental principles that are invariant throughout time and space. There are fundamental principles that don't change.

- People have a basic right to safety and it is a fundamental obligation of all governments to ensure that their citizens are protected to a reasonable degree from known risk and those citizens are informed and warned of any risks known to governmental officials that threaten public safety.

- To respect the equal dignity of all human beings, recognizing a basic right to life and subsistence.

- The condemnation of coarse public sector corruption and obligation to respect human autonomy.

This came from the book The Search for Principles of Disaster Management and all of these resources are listed in Moodle. I recommend you take a look at them.

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Presenter: Patricia Reynolds

Relevant ethical principles came from a wonderful report called “Stand on Guard for Thee: Ethical considerations in preparedness planning for pandemic influenza.” This is a report out of the University of Toronto in 2005 as a result of the SARS epidemic. This is the first substantive report on how we deal with our society during these times.

It would be interesting here to describe individual liberty. How would that become an ethical principle during this time? I will go through a couple of these: protection of the public from harm. One of the ways we can protect our public from harm is to have shelter-in-place, the use of masks, vaccine quarantine, and so on. Reciprocity, memorandums of understanding, and sharing of resources. Equity would be fairness. Solidarity would be working for the good of the whole community and stewardship might mean managing, preparing, and allocating scarce resources. We have memorandums of understanding here in Florida with all of our hospitals. That has to be tested and when the time comes. We had several problems here when we had the last pandemic in cases of sharing of flu vaccine got to be quite a problem. I will add a few little personal knowledge stories as we go along.

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Presenter: Patricia Reynolds

This is another slide that really goes over the same principles.

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Presenter: Patricia Reynolds

We are going to go into the history of ethics in medicine.

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Presenter: Patricia Reynolds

We have some slides that didn't make it in here. These are not the same slides we had the other day. So when you go into the slides on the Moodle program we will have to go over that and show you where there are extras slides there.

The Hippocratic Oath is the oldest of our physician oaths. I am not going to go through all of these but all of the writing that is on there you can actually see what it is. “I will do no harm and I will not use the knife, not even on sufferers from stone but will withdraw in favor of such men as are engaged in this work” and so on and so forth. However, the Hippocratic Oath is one of the oldest binding documents in history, written in antiquity; its principles are held sacred by doctors even to this day.

Yet, paradoxically, even as the modern oaths’ use has burgeoned, its content has backed away from the classical oath basic tenets. According to a 1993 survey of 150 U.S. and Canadian medical schools, for example, only 14% of modern oaths prohibit euthanasia. Eleven percent hold covenant with a deity and 8% foreswear abortion and a mere 3% forbid sexual conduct with patients. All maxims held sacred in the classic version. The original calls for free tuition for medical students and for doctors never to use the knife, both obviously are out of step with what goes on today. Perhaps most telling, while the classical oath calls for the opposite of pleasure and fame for those that transgress the oath, fewer than half of the oaths taken today insist the taker be held accountable for keeping the pledge. I am not going to go into any more about the Hippocratic Oath.

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Presenter: Patricia Reynolds

Let's go on to see what we have with earlier oaths. As we said, the Oath of Hippocrates was 4th century. These are oaths that we know in the Encyclopedia of Bioethics. They were in place up until the 20th century. The Code of Ethics of the AMA came to being in 1847.

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Presenter: Patricia Reynolds

As we go on to the next slide you will see a tremendous difference in the number of oaths. It is interesting to discuss at this point why these all came to be and why they all came to be in the 20th century. We have the Declaration of Geneva 1948 and the International Code of Medical Ethics in 1949; these are the results of the Second World War.

The development with the press and more people knowing about things that went on certainly had an effect on this. We have all the different countries having medical oaths and again we come up to all the ones on the right-hand side being newer as we move along.

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Presenter: Patricia Reynolds

One thing I am not going to do is to focus on global ethics. I am just going to touch on it lightly, but international ethics and the ethics that deal with armed conflict we won't go into too much. Global ethics and human rights were first explicitly declared internationally in 1948 in the United Nations' Declaration of Human Rights. It is not an international law but a global paradigm. We have the United Nations Charter and the Health for all in the 21st Century by the World Health Organization. As we move down the list, we have the United Nations Resolution on the "Right to Intervene," International Humanitarian Law, and the Helsinki Declaration, which protects patients' rights and integrity with regard to research. This has been endorsed at the General Assembly of the World Medical Association in Helsinki in 1964.

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Presenter: Patricia Reynolds

We can move on to professional codes of ethics and we have done some work in this and virtually every licensed credential person has a code of ethics as part of their organization. This comes again from Naomi Zack's book. "Professions covered by Codes of Ethics approved by their members function on the assumption that these codes will not be violated in practice. When they are violated, practitioners may be guilty of malpractice, incurring criminal as well as civil and professional penalties."

When we can look at the last few disasters we've had and we can see a lot of questions have come up with professional codes of ethics. During Katrina and during the Memorial, the article you read in the New York Times, this is what we look toward when we look toward a code of ethics because it will stand up in court also.

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Presenter: Patricia Reynolds

We will move along a little bit and come back to this topic in a bit. We live in complex times. We live in very complex times; famine in Africa, Bhopal.

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Presenter: Patricia Reynolds

I have another slide that was part of this that showed the Joplin Hospital that was totally destroyed. And of course Katrina which certainly impacted all of us. When we get to this, these are questions that impact us with regard to why we do the things we do. The ethical considerations that we need to look at.

Solidarity, the principle of solidarity and social cohesion provides us an excellent example of the value of the analysis of multiple levels: individual, community, national, and global. This principle relates to how united and connected and cooperative a society is. A socially cohesive society is one that tolerates and embraces cultural diversity, a society with the vast majority of citizens respect the law and human rights, and where there is a shared commitment to social order and communal responsibility.

A tension may exist between the liberal tradition that emphasizes individualism and the principle of solidarity and social cohesion. You might say that somebody who feels they don't want to act in solidarity with the other members of society, but wants to go off on their own and not be told what to do, might be something that is looked at in this regard.

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Presenter: Patricia Reynolds

These are very important principles as we move along here; joint responsibility and nondiscrimination.

Joint responsibility emergency management is not solely the domain of emergency management agencies. Rather, it is a shared responsibility between governments, communities, businesses, and individuals.

In our county, I have been fortunate to work on our emergency management team in the hospital. For a long time after I first started doing this as a librarian embedded in the team, we had no clinical people working on the emergency management team. It was basically our security department. It was so necessary to be able to pull all the clinical elements together and make them all part of the team.

That goes also to our supply-chain people, our psychological counselors, and so on and so forth. That has changed since we began to really look into working on the question of disaster preparedness. We look at inclusion and needing to break down barriers and silos. We also work with our county and with our health department and all the other government agencies and also our faith-based groups within our community.

Non-discrimination is a principle of FEMA law and federal civil laws. Civil laws in section six of this guide required equal access for and prohibited discrimination against people with disabilities in all aspects of emergency planning, response, and recovery. To comply with federal law, those involved in emergency management should understand the concept of accessibility and non-discrimination and how they apply in emergencies. We're going to go on a little bit more this is a very important aspect of the Americans with Disabilities Act and how we deal with all of these from ethical points of view.

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Presenter: Patricia Reynolds

Another guiding principle is the principle on internal displacement. This is a picture of Hurricane Katrina and the guiding principle on internal displacement was unanimously adopted by the United Nations Commission and the General Assembly. Internally displaced people shall enjoy, in full equality, the same rights and freedoms of those who were not. Children, unaccompanied minors, expectant mothers, and the elderly need to be given special treatment when they are internally displaced.

I am bringing this up because of what happened when Hurricane Charley came through Punta Gorda, Florida, in 2004. The hurricane was on a very similar track that hurricane Isaac is right now and when it got to Punta Gorda and the Peace River, it made a right-hand turn. I believe it was a category four. It was very narrow; it was very focused. It tore up the river and literally destroyed all the housing around Punta Gorda and Port Charlotte, including the local hospitals. I will tell you a story about that too.

We ended up getting the trailers that have been used for Katrina. Trailer City was set up along I-75. We had people who lived there for years until we had to say they had to go. I think Trailer City was finally disassembled about two years ago. That was a very hard time. There were two hospitals across the street from each other in Punta Gorda and Port Charlotte—Fawcett Hospital and St. Joseph's Hospital. The emergency department of the St. Joseph's hospital and the cardiology area was damaged during the hurricane. So in principle of reciprocity, Fawcett Hospital across the street said that they would take over those services until St. Joseph's could reestablish. Once St. Joseph's reestablished, Fawcett did not want to give up the services. That is some of the processes and services that can have problems during the questions of reciprocity in getting back on track afterwards.

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Presenter: Patricia Reynolds

Then there are questions of impartiality. The American Red Cross as a member of the International Red Cross and the Red Crescent Movement adheres to the fundamental principles of the International Red Cross and Red Crescent Movement. Specifically the principle of impartiality states, “It makes no discrimination on race, religious beliefs, class, or political opinions. It endeavors to relieve the suffering of individuals, being guided solely by their needs.”

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Presenter: Patricia Reynolds

Here we saw this in Haiti. They do a tremendous job and certainly in the United States, as well in other circumstances.

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Presenter: Patricia Reynolds

The Code of Conduct for the International Red Cross was drawn up in 1992. Since that time we've had, as of now, we have 492 signatures from countries around the world that adhere to the Code of Conduct of the International Red Cross.

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Presenter: Patricia Reynolds

If anybody has any questions please use the chat room to ask or contribute or stop at any point. If you want to share anything I am open to that. Please feel free. We can certainly use the back-and-forth discussion.

What I'm going to get into now is something that is one of the most important aspects of our modern- day ethical problems and that is the standard of care. What is the meaning of the standard of care? How did Hurricane Katrina affect our understanding of the ethical implications of our standard of care? How was the concept of triage affected by crisis standards of care? What are the legal implications of crisis standards of care?
I will tell you a little story about this as we move ahead.

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Presenter: Patricia Reynolds

The standard of care from the American College of Medical Quality states that it is “a case- and time-specific analytical process in medical decision making, reflecting a clinical benchmark of acceptable quality medical care”. This benchmark, which is used to evaluate and guide the practice of medicine, encompasses the learning, skill, and clinical judgment ordinarily possessed and used by health care providers or payers of good standing in similar circumstances.

This is really important. The standard of care must reflect the arts, consensus opinion, and the science published peer-reviewed Journal of Medicine and must be uniform for all healthcare personnel. We have to understand it is not something that is written down as a policy, it is something that healthcare professionals are expected to behave in a way that gives their best to every situation they are in. A violation of standard of care basically comes from their code of conduct. A violation of standard of care may result in underutilization of medical care but also occurs if unnecessary care is provided. The standard of care has a national clinical basis rather than a local provider community or payer review basis.

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Presenter: Patricia Reynolds

At this point we want to talk about how standard of care became such an important part of our medical ethical world. If you read the New York Times article by Sheri Fink who recognized what happened with Dr. Pou. The effort was to indict her because, according to the Attorney General, she did not adhere to the standard of care. This is when these questions became really important. In 2009 the Institute of Medicine and AHRQ sought national public input in creating a unified standard of care for disasters and emergencies. They set up meetings in four cities around the country: out West, Orlando, New York, and Chicago. They invited anybody who had an interest in the topic of altered standards of care to come and participate. They had a wonderful panel of speakers. I happened to attend the Orlando conference and it was very interesting because they had people from all different parts of the United States talking about how they viewed standards of care.

Oftentimes in these situations, standards of care refer to triage and allocation of scarce resources. I mentioned the fact that one of the doctors of the University of California-Davis said that if they had an earthquake and they were hit with a lot of people coming to the hospital they would say, that if the person didn't have a 50% chance of survival, they would not be treated. There were a lot of gasps and a lot of questions about standards of care. As I say they were originally called

altered standards of care and we have articles in PubMed, if you look up altered standards of care you will find them.

This is a personal story about me. We were in Florida trying to work on the ethics in disasters. We know you have to submit questions of ethics to the public; you have to have town meetings, you have to have discussions with the public to agree to a consensus and they have to understand what is being done. In Florida there was an attempt to develop a standard of care. Our hospital lawyer found out I was looking for the updated Florida standard of care. I happened to be on a cruise in Germany at the time when she realized this. She sent me an e-mail huffing and puffing that I was never to discuss the words “altered standards of care.” We do not alter our standard of care or lower it. In other words altered standards of care would refer to lowered standards of care. I was taken to task in no uncertain terms. That raises a lot of questions as we already have a lot of literature published with the title containing altered standards of care. So was I not supposed to put those in a bibliography? That would raise other issues of the censorship possibly so on and so forth.

The IOM Committee came out with the idea that they had to change the word “altered.” Today we call them crisis standards of care and in all the literature you'll find they're called crisis standards of care. It's a very sensitive topic that is going to continue to be a sensitive topic as we go along until we finally have it worked out and the public is aware and knows what is going on and there is a consensus.

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Presenter: Patricia Reynolds

The recommendations are that from the IOM in developing crisis standards of care. There are five key elements. One is strong ethical grounding and two is integrated and ongoing community and provider engagement, education, and communication. Just the kind of thing IOM did around the country; this should be done within each state in developing its own crisis standard of care. Three is assurances regarding legal authority and involvement; four is clear indicators, triggers, and lines of responsibility; five is Evidence-based clinical processes and operations. It is a fine report; I've also included it on Moodle and I would like to bring it to your attention.

[DISCUSSION]

I just noticed there are some questions here. Bob Pringle in Spokane said, “I was intrigued to see the New York Times article reference to nine different approaches to definitions used in triage.” We can go over that and you're absolutely right. I have come up with five that I have kind of looked into, but you are right. And Lisa said, “Yes there are many different approaches, but it can also differ by population.”

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Presenter: Patricia Reynolds

They also suggest you seek community and provider engagement; special attention should be given to vulnerable populations. You need to adhere to ethical norms during crisis standards of care. Dr. Zack recommends that disaster preparation is more important from an ethical perspective than the process during the disaster because we have to have a way of thinking about things before they happen. That is very important. The condition of overwhelming scarcity limits autonomous choices for both patients and practitioners regarding the allocation of scarce resources. But, do not permit actions that violate ethical norms. We provide necessary legal protection for health care practitioners and institutions. Implementing crisis standards of care and we ensure consistency and crisis standards of care implementation with triage teams, palliative care, and mental health and pay attention to vulnerable populations. We ensure intrastate and interstate consistency among neighboring jurisdictions.

That's also an important aspect. We went through this with Haiti here in Florida because so many of the critically ill people were brought to Florida. They had so many coming into Miami that they moved many of them up to Orlando and various hospitals close to us. We were monitoring daily as to whether we were going to be getting those patients. We had to be on the same wavelength.

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Presenter: Patricia Reynolds

The Institute of Medicine has created this wonderful page of templates: Guidance for Establishing Crisis Standards of Care for Use in Disaster Situations and Crisis Standards of Care: A System Framework for Catastrophic Disaster Response. These are vital templates to guide the efforts of professional and organizations responsible for CSC planning. The templates are on the Web page that I have linked there. One is downloadable PowerPoint briefing slides, a guidebook, table facilitators, and note takers of the facilitator guidebook, sponsored guidebook, state and local core functions for plan development, EMS core functions, and so forth. So they have really laid out exactly what everybody needs to know when developing standards of care. So, I am going to show you a little bit of what we have here.

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Presenter: Patricia Reynolds

This is the IOM: Continuum of Incident Care. It has the three S's: space, staff, and stuff, or supplies. Standard of care would be the fourth. The potential for crisis standards, and then they

outline the trigger and I think this is really the important thing. For instance, the first one would be space. They went into crisis standards of care I am sure in Joplin when the hospital was damaged. Staff: when we ran into problems when pandemics or flu season comes and staff is not available and critical supply is lacking too with regard to pandemics.

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Presenter: Patricia Reynolds

I want to show you this template. You can take this out and use it at local organizations; I have given talks at nursing homes and to our Bioethics Committee.

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Presenter: Patricia Reynolds

These are freely available for you to use, these are parts of the slides from the template.

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Presenter: Patricia Reynolds

How is disaster defined? Preparing for Disasters: The challenge. It is written in a way that most people can understand.

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Presenter: Patricia Reynolds

This is a recent example of the H1N1 pandemic in which we had a vaccine shortage. That was an interesting one because based on the information from the Toronto algorithm. I actually gave this as a talk at a nursing home on the Toronto algorithm anyone older than 80 would not get any vaccine. Then you had EMS workers and healthcare workers getting vaccines first. These are all ethical questions that need to have discussion in the public.

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Presenter: Patricia Reynolds

Then you have people that say “I can afford it. I should be able to get it no matter what.” That is not quite the case.

Here we have guidelines developed before disaster strikes to help health care providers decide how to administer the best possible medical care when there are not enough resources to give all patients the level of care they would receive under normal circumstances. All this is to develop a legal framework to help us out.

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Presenter: Patricia Reynolds

I don't know why but we ran into this before when we did a webinar with these slides certain things don't show up. I could tell you there are no action buttons in these slides so I have no idea why this is. If you look at the slides online you will see, why we might need crisis standards of care. Basically they have what they call extreme crisis resources. You need to take a look at the slides online it is very important.

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Presenter: Patricia Reynolds

How are crisis standards of care different? The focus is on normal care for the individual; the focus on crisis care is toward the community. The picture is on the slide. It just doesn't show up in the webinar.

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Presenter: Patricia Reynolds

Possible reasons for the crisis standard of care are to make sure critical resources go to those that will benefit the most, to prevent hoarding and overuse, to conserve limited resources, and to minimize discrimination against vulnerable groups. All people can trust that they will have fair access to the best care possible.

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Presenter: Patricia Reynolds

Possible strategies to maximize care: is space. With our ASPR Grants, we have been able to turn an entire floor of our garage into an alternate care site, which can serve just about anything we need to do and we are very excited about that. We had several drills using it and it has been quite remarkable. We can now house 20% of our beds supply. Normally we have 500 usable beds so we can put 100 people on cots in that alternate care site. That is along with their decontamination area as well.

We have supplies, sterilized and reused disposable equipment, limit drugs, and prioritize comfort care for patients who will die. When we started doing this several years ago, not much was taken into effect with regards to 95 masks. We found out that we didn't have access or availability to enough 95 masks to do what we needed to do. Nor did we have enough ventilators at all to take care of a possible overload of patients—the surge, obviously. I would mention here that we have done a lot to ameliorate that. In the last year they have come out with really cheap ventilators. Our doctors said to me one day, “You may be buying generators, but you may also end up buying a ventilator and everybody will have their own ventilator.” They run about $500 now, I think. They just do the basics in terms of keeping you breathing.

Then we have nurses providing care the doctors usually would provide and family members and so on. We are seeing this now today because we have people with special needs to come to our hospital. We have had to allocate that and work with our county to take on more of that responsibility because it was becoming overwhelming. We take people who have dialysis needs. We have about 50 now but at one point we had 200 coming to the hospital with their caregivers, so it got to be a little bit much.

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Presenter: Patricia Reynolds

What is the manner in terms of who gets what? Is it first come, first served? Is it a lottery system? Is it save the most lives possible by giving more care to people who need it the most? There is the “saving all you can” thought or the “saving all who are going to live” thought. Do you favor certain groups? The old or the young? Do health care workers and other emergency workers get priority? Do utility workers and government officials get priority? You can go through the pros and cons of all of these. They are all available and these are ethical decisions which really need to be decided very early on before you move on.

[DISCUSSION]

Siobhan is saying if you limit care to patients, that is very much an ethical action. You are certainly absolutely right.

You do limit care to patients in many cases and every disaster conference I have been to the question comes down to what basis you are going to say to people “Come back later.” The walking wounded. How we determine who the exact people are who are going to need critical care? There is a conference at the University of Miami every year on disaster planning and Dr. Mauricio Lynn does a wonderful talk. He actually worked in Israel and talks about the fact that if you have an explosion or terrorist attack, something like that, you’re going to have to say, if people can walk to the hospital or can be brought to the hospital, no matter what it is, you’re going to have to determine what it is that will make them functional. Then they could be taken care of later. His feeling is very strongly that under most circumstances, only 10% of the patients that need help are really going to need critical care help. It's going to be a relatively small number. We saw that in 9-11, only 300 people who were wounded and of that 200 some odd or whatever. That is the question… when you get into a bomb blast or explosion, when you have a pandemic that is the whole another issue.

You have to decide: Are you going to give the benefits to those that have the longest quality of life still available to them? That is an important question. I don't have anything to say about this other than all of these questions have to be taken into consideration.

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Presenter: Patricia Reynolds

Where do you come in? These community conversations help policy makers. You have to understand this is a really wonderful way to get involved with your local health department and also to give talks within your hospital and communities to raise the awareness.

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Presenter: Patricia Reynolds

And I love this, I have seen this many times. This is crisis standards of care: a piece of the puzzle.

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Presenter: Patricia Reynolds

[ACTIVITY]

If we go into the Sheri Fink article about The Deadly Choices at Memorial, I think we do polling here. These are some questions I had. “Which of the following ethical considerations do not apply to the Pou case?” Staff I am going to have to ask, if I click on this, is there polling going on here? No? I guess we're not going to have polling. Yes, we are going to have polling. I am not quite sure how we do this but which one of the following ethical considerations does not apply to the Pou case? And people can respond in whatever way they would like. And I will give you a second to go over that. Are you there Deb? Thank you.

Siobhan is making up the poll right now.

I am sorry. Thanks, Siobhan. There is the poll, thank you. Okay. Some responses, are you all taking part? I hope so. I will go over this with you and when I made the question I have to tell you I chose neutrality because neutrality was an ethical consideration mostly dealt with in international conflict or international relief. So neutrality was one. However when we discussed this on Tuesday, informed consent was one other choice people felt was important too. It was part of informed consent, it was discussed in the article but the ethical consideration of neutrality was the one I was looking for. It goes to show—you can discuss these things for quite a bit. Can I close the poll? And go on to the next one? Okay. Thank you, Siobhan.

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Presenter: Patricia Reynolds

[ACTIVITY]

The next was “What type of triage was set up in the Memorial?” I can wait a minute if you want to do that or we can discuss. Thank you, Siobhan. Was it the sickest first? I will wait until Siobhan puts it up there. The choices are sickest first, lottery, and sickest last or random selection. I will just give you a few more minutes to pick. Most of you thought it was sickest last. She did talk about different aspects of who was sick and what were their conditions. Would they have a good quality of life after? It was very much a question of the sickest would be taken out at the last minute which obviously was one of the reasons why they did what they did at the time. I have a lot of questions about my own personal feelings about the article. I won’t go into it too much but one of the things that struck me, another book written at that time about how HCA hospitals and large corporate hospitals came in with helicopters and got everybody out so quickly. Now we are looking at one floor of a hospital, an old hospital, and their probable lack of planning for how they would get patients out. I’ll add a little bit to this. I love to add personal things here. When we

started working on this about four years ago, our security department was in charge of our emergency management team. We really did not have any involvement with the clinical staff at all.

One of the things we started to say is “How can we have drills where we actually go up to the floor and have nurses do things?” After working very hard, we finally got nurses involved on the committee and they finally decided to have a drill that would involve the evacuation of patients. We had Stryker Chairs in the hallway and stairway, and they found out right away that nurses could not use the Stryker Chairs. They were very ineffective and we did not have enough emergency security people to evacuate everybody using a Stryker Chair. It was at that time we went to meetings and conferences. Today every single room has one bed sled and every double room has two bed sleds. Every nurse has been taught how to use a bed sled. We had a drill which we evacuated half a floor and we will do more and more of those because this made all the difference in the world.

[DISCUSSION]

Arletha Ford said, “Remember the director of nurses had a 246-page disaster plan that lacked any method of getting people out of the floor”. Yes exactly.

So preplanning is crucial and I think we've learned a lot. We do have an evacuation plan now, thank goodness. We did not have that before and getting people to do it over and over and over again is so important.

Now I also have another slide I am just going to have to tell you about. I want you to be aware of regulations that apply to physicians in emergencies, the EMTALA Act. The EMTALA Act did not apply to Dr. Pou. Her patients were in-patients; they were not emergency room patients. Louisiana's Good Samaritan Law did not apply to Dr. Pou because she was an on-duty staff physician. If she had been in a car accident or had arrived at a car accident that would've been different. The Model State Emergency Health Powers Act originating from CDC in 2001 did not apply to Dr. Pou because it required proof of gross negligence. In 2003 the Health Emergency Powers Act passed in Louisiana. It provides immunity to physicians working in emergencies in 44 states and the District of Columbia. Somebody asked me whether the other states did not sign up and I do not know.

I would like to read you something important. This came from the Virtual Mentor of the AMA. As evident in the grand jury decision not to indict her, Dr. Pou has numerous supporters who consider her decision heroic. Rather than abandon patients, she remained at the hospital with them for four days without adequate sleep, food, water, resources, or manpower. According to the America Medical Association Code of Medical Ethics, individual physicians have an obligation to provide urgent medical care during disasters. That holds even in the case of greater than unusual risk to their own safety health or life. It is not speculative to state that Dr. Pou and the Memorial staff put their own health and safety at risk in the atrocious post-Katrina environment and successfully evacuated the majority of Memorial’s patients despite life-threatening

conditions. The AMA commended Dr. Pou for her efforts and the chair of its board of trustees stated, “We believe these physicians served as bright lights during New Orleans’ darkest hour.” I wanted you to be aware of that support from the AMA. She certainly has civil suits still outstanding.

[Slide 45]

Presenter: Patricia Reynolds

Ethical principles applied prior to disasters. This is almost a checklist of what one should do prior to a disaster. Introduction of prevention measures, measures that can be important during pandemic or anything like that; importance of good quality healthy environment; education training, and awareness rising. Over and over again, participation public input at national and local levels; freedom of expression; access to justice; disaster prevention at the workplace; disaster prevention in recreation tourist areas; disaster prevention in public places schools and hospitals; special prevention measures for the most vulnerable groups; organization of and participation in emergency drills; and preventive evacuation of populations. This is a good checklist for how you can employ ethical principles prior to a disaster.

[Slide 46]

Presenter: Patricia Reynolds

So there are various different ways and if we had you all being able to speak to all of us, we can discuss the different types of ways to prevent, to get ready for pandemics, natural disasters, burns, bombs, explosions, biological, and terrorism. Again I recommend the University of Miami Conference, which is being held every year and there are many others in Washington and all over the country.

[Slide 47]

Presenter: Patricia Reynolds

Preparations. Again, you need to be able to select what kind of triage you’re going to be involved in. How you will distribute scarce resources? Is it going to be with a lottery? Planning must occur before a disaster to alleviate any influences made by people that could cloud their moral judgment, must be general in scope, but not too general that it doesn't mean anything, and it must express our best moral principles.

[Slide 48]

Presenter: Patricia Reynolds

This is a community strategy plan that came out of globalsecurity.org in terms of an algorithm for dealing with pandemic influenza mitigation. It is an example of the kinds of recommendations and information you can look for to provide in talks or Power Points to explain to people when to move into a different state of preparedness.

[Slide 49]

Presenter: Patricia Reynolds

The ethical approach to allocation of scarce resources and triage: Fairness have to be just to all individuals; you have the duty to care; duty to steward resources; to attempt the best outcome for the greatest number with available resources. It does not mean to save the most lives. A comfortable death may be a good outcome. This comes from an article in the Annals of Emergency Medicine. One of the authors, Dr. Dan Hanfling, also on the IOM steering board there, was very greatly involved in this.

Transparency, everybody has to know what you are doing and why you're doing it and consistency, proportionality, and accountability.

[Slide 50]

Presenter: Patricia Reynolds

We get our resources from Fort Myers; our trucks come from Fort Myers because we are involved with the hospital and Lee Memorial Hospital in Lee County south of us. We had to get resources from Lee County. One of the things we spent a lot of time discussing was how would we provide protection for the trucks that had to move from one county to another county. It's an interesting conversation, but nevertheless it was quite real. We have to depend on the other county to stand behind us in what we were doing.

Public health decision making is concerned with populations rather than individuals, greatest good for greatest number, public health interventions must be necessary and effective to address public health issues, and again, always a need for a fair process and transparency.

In our situation here in public health we rely a lot on our Communities Organized Against Disasters (COAD) to work with faith-based organizations. Those are the groups where ethical questions will also be discussed at great length.

[Slide 51]

Presenter: Patricia Reynolds

Principles of allocation are who are the people who will benefit the most? Will they be health care workers, government employees, policemen, or people who have more money and can afford to buy whatever they need? You have principle of social worth, of instrumental value. Is it going to be random selection again? Are there going to be principle of fair chances? Anyone needing resources gets them until they all run out? Allocation based on age seeks to maximize the quality of life years and life cycle principle; a child would receive preference. Allocate resources to those most likely to survive to hospital discharge.

Remember what I said about California; they said that if they don't have a 50% chance of survival, they were not going to be given critical care treatment and sickest first obviously. When we talk about these, there are issues of allocation of scarce resources and triage. All seem to meld in together in so many ways.

[Slide 52]

Presenter: Patricia Reynolds

ADA and the Rehabilitation Act is one of the things I felt very strongly about. The article I reference here is also on Moodle and it is by Wendy Hensel and Leslie Wolf called “Playing God: The Legality of Plans Denying Scarce Resources to People with Disabilities in Public Health Emergencies” from the Florida Law Review. It is excellent. It says that we must value the judgments and worth and quality of human people and according to state and federal law, the disabled must be treated equally to all other people.

Well, that kind of creates some issues. If you have a person who is injured in a crushing injury, say an earthquake or something like that, and received neurocognitive impairment, would you treat the disabled person with neurocognitive impairment the same as you would treat a person who did not have one? The person who might have been injured would not possibly receive the same treatment. I can tell you this; they have not come to a conclusion on this. I would like to point that out. This is still an open discussion.

[Slide 53]

Presenter: Patricia Reynolds

Here we have Title II and Title III and they probably preclude discrimination against people with disabilities on the basis of their impairment. So if a person has lost legs in a disaster, how would that be dealt with? As opposed to a person who was born with that impairment and is disabled?

All public hospitals and service providers are covered under Title II ADA. They cannot discriminate against them. The regulations define discrimination to include providing an aid, benefit, or service not as effective in affording equal opportunity and the same result, getting the same benefit, or to reach the same level of achievement as that provided to people outside of the protected class. So I am going to leave you with that. I have read through on this and I hope that Barbara will be able to help you tomorrow and you can move through that. This is one of the legal issues where we have the clinical and medical ethics and legal issues that come along.

[Slide 54]

Presenter: Patricia Reynolds

The reasons for excluding the disabled in the algorithms will be that individuals will need resources for a prolonged period of use. They are deemed to have a poor quality of life in post-treatment. They have limited long-term prognosis as a result of their disabilities. All of these are antithesis of what we discussed earlier with regard to how we view triage in other ways or allocations of scarce resources. The same exclusions that might apply to the nondisabled may affect the disabled, again neuro and cognitive impairments and so on and so forth.

[Slide 55]

Presenter: Patricia Reynolds

This is ethical principles applied during disasters from humanitarian assistance, information and participation during disasters, compulsory evacuation, respect of dignity, emergency assistance, and rescue workers and necessary measures to safeguard and restore social ties.

[Slide 56]

Presenter: Patricia Reynolds

Ethical issues during a pandemic. Health care worker continue to provide care during communicable disease outbreak, restricting liberty, quarantine, allocation of scarce resources, and global governance.

Now I want to talk about pandemics with regard to professional issues of codes of conduct.

I did bring this up the other day. It is really important. All licensed professionals sign a contract as part of their employment. They have a contractual commitment under the code of conduct to care for people. However we know 30% to 50% of the allied health care workforce will not show up during a disaster or pandemic. Those are the problems we need to address because they have to know right up front that this puts them at higher risk for keeping their jobs in some cases. Physicians also have the same responsibility as part of their contract to their patients. You cannot just abandon a patient so you can't say, "Well, a hurricane is coming, I'm going to Orlando, and therefore they will go to a hospital if they need to get help." You can't do it. You have to determinate a patient legally or you have to arrange for coverage with another physician. These are very important ethical and legal issues that put people at risk. I know this happened at other hospitals where nurses have not shown up. The code of conduct of nurses says you have to take care of your patients, but you also have to take care of yourself and your family. So there are different thoughts in many of these as to which is going to supersede—whether you take care of your family or your patients. Many times it comes down to "Do you still want your job?"

And of course then it's a question of are you going to. We have instituted a situation here where if you don't get vaccinated, you cannot continue to work on a patient floor. There is quite a lot of blowback about that, as you can imagine. I do know in New York there is a law, and we instituted it a year ago along with other hospitals very quietly, but it is working.

[Slide 57]

Presenter: Patricia Reynolds

After disasters we need to get people back on their feet. We need to get society in place again businesses working, houses fixed up, and people eating, comfortable and continuation of business as it was.

[Slide 58]

Presenter: Patricia Reynolds

Here is my big question here, I have a couple more but we actually are getting close to the end here. Who is going to ask you questions like this? My suggestion to you and I know the suggestion of the National Library of Medicine is that you embed yourself or embrace the Emergency Preparedness Committee in your hospital. Although in the beginning, it may be a little bit odd but it certainly is something that I found to be extremely beneficial. One of the things if you don't have an emergency coordinator you can do is find grants that are available. You get an awful lot for taking people to conferences. You can also become a member of the bioethics committee and champion this ethical approach to disasters through your bioethics committee. You have public health agencies and departments who have their groups that go out to local organizations; communities organize against disasters. COAD and they bring in people from the public to help do

this as well. You have physician and nursing education opportunities. I have given CME talks on this before and you have CEU opportunities with regard to nursing presentations.

I can guarantee you that so many of these groups are not aware of the implications of so much of this. You can give presentations to local nursing homes and assisted living facilities and other community organizations and, most importantly, to local faith-based minority organizations. Huge. It would be tremendously helpful to do that.

[Slide 59]

Presenter: Patricia Reynolds

This is my slide on our COAD. I'm sure you have these kinds of groups available in your community. Try and bring all members of the community together to discuss ethics and disasters and what your community can expect. Bring out the conversation and make it transparent and publicly available.

I want to bring you back to one little story. Florida finally got around to developing its draft form of our crisis standards of care. It took a long time. I did find it in my files and I did put it on Moodle. So if you're interested in seeing how Florida dealt with this, go to Moodle and take a look at it. They did not use the word about crisis standards of care; they just used the word about allocation of scarce resources and triage or something like that. It is not mentioned.

[Slide 60]

Presenter: Patricia Reynolds

I am a few minutes early because I have a couple of slides that did not get in there but I want to give special thanks to Naomi for allowing us to use her book on our website, and of course Cindy Love, Siobhan Champ-Blackwell, Debra Cavanaugh, Jenny Pierce, and Stephanie Bauer also volunteered the University of Alaska Anchorage, and Barb Folb. We will hear from tomorrow.

[DISCUSSION]

So I would love to know if anybody has any questions and they want to chime into the chat room. Can I end this here? Siobhan? Hello?

Yes.

Or open the phone lines to see if anybody wants to ask anything?

I am going to try. If you want to talk, press star six, all of a sudden I can't remember what the code is to un- mute everybody, so you can press star six on your phone.

I would love it if somebody wanted to add anything that I left out.

I will just say I think it is really the whole ethical questions that come up is easy to talk about now and it is important. It's easier to talk about them now and is a really important. The article was, I think, a great article to demonstrate when you are really right there in the midst of the chaos and you have to make those decisions. That is a horrible place to be and to have had these standards of care written up for you, to tell you what to do, and to take away the need to make those decisions, I think that would be really important.

The other thing is it will be interesting to see how broad standards of care are. I don't think you will get down to an exact definition of what a person would or would not do, but they are going to be broad enough to make it possible for people to act without fear of intimidation or being sued or whatever. I think that will be it, I think, the most important thing would be to go back to some of the standards of care, take a look at them, and see what they are, and how they affect the medical community. So, anybody else? No? Thank you for letting us do this. I hope I'm not too early in letting you go.

Maybe if you let them go five minutes early, I will make them stay five minutes late.

Okay. I am sorry about the slides; I think we covered everything we wanted to. Okay?

Thanks so much it was great.

Thank you shall we go now? You're welcome, thank you. I am just getting chats here. Thank you very much. Anytime, these are great topics to talk about and think about so. I'll say one more thing for anybody online, we talked about this day before yesterday in Naomi Zack's book she gives different stories about ethical they are stories that represent ethical choices. And the one that I love is the fat man in the cave. A group of people went into a cave and a fat man got stuck, leaving the cave. So his head is outside the cave and all the people are behind him in the cave. And the water is starting to build up. And if they can't get the fat man out of the cave, they will all drown. There is one man who has a stick of dynamite with them. So the question is, "Is it morally ethical to shoot the fat man out of the cave with a stick of dynamite to save the many? Or, should they all die for the sake of the one?" I just thought it was a compelling question and lot of food for thought too. I just wanted to pass that on. She's got a lot of stories like that I highly recommend. Well, thank you very much. Good to talk to you all. Bye-bye.

[Event Concluded]