Restrictions, Rationing and Responsibilities: The 3 R's of ethics in disaster response

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Objectives

• (Very) Brief overview of legal and regulatory framework of disaster response

• Discuss 3 core ethical issues common in disaster planning and response
  – Responsibility to care despite personal risk
  – Restrictions on personal liberties
  – Resource allocation dilemmas
Legal Background:
Individual Rights in the US

• U.S. Constitution: 5th and 14th Amendments guarantee due process & equal protection

• Restricting individual liberty ONLY with
  – Compelling interest
  – Well-targeted intervention
  – Least restrictive means necessary
  – Due process
# Federal and State Roles

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<td>• Interstate commerce</td>
<td>• Public health law</td>
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<td>• National defense</td>
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<td>• Tax &amp; spend for public welfare</td>
<td>– Act to protect public health, welfare &amp; morale</td>
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<td>– Public health emergency powers</td>
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Public Health Emergency Powers

- Surveillance
- Reporting
- Epidemiological investigation
- Power over property
- Voluntary or mandatory
  - Vaccination
  - Isolation
  - Treatment
- Social distancing
- Evacuation
Disaster Declarations

• State initially declares state of emergency

• Declaration triggers public health emergency powers

• State requests assistance
  • HHS Secretary for public health emergency
  • President via the Stafford Act
Federal Context

• Insurrection Act (1807): limits use of federal forces within states

• Posse Comitatus Act (1878): prohibits use of federal forces for law enforcement

• Stafford Act (1988)
  – Governor requests assistance
  – President declares disaster
  – FEMA responds
Possible Military Role

Three Pillars of Civil Support

- Local Executive
- Governor
- Secretary DHS
- U.S. President

- Joint Field Office
  - Principal Federal Official
- Defense Coordinating Officer
- JTF-CS
- Secretary DOD
- U.S. Northern Command
- DOD Task Force Response Assets

- First Responders and Local Assets
- State Emergency Management Assets
- Federal Emergency Response Assets
I. Responsibility to Provide Care

- Not found in the Hippocratic corpus
  - Though duty to care for the poor is there…
  - Physicians warned against treating those “overmastered by disease”

- Advice to physicians during plague
  - cito, longe, tarde

- Not found in early texts on medical ethics
  - Including the Royal College of Physicians attempt at a code of conduct in 1543, which was written during a London plague!
  - Including that of Percival, the physician who coined the terms “medical ethics” and “professional ethics”
I. Responsibility to Provide Care

• First national code to articulate duty to treat

When pestilence prevails, it is the physician’s duty to face the danger, and to continue their labors for the alleviation of suffering, even at the jeopardy of their own lives.

1847 AMA Code of Medical Ethics
Ethical Bases for DTT

• Profession’s Social Contract/Reciprocity
  – To accept benefits of professional status one must also fulfill professional obligations

• Special training: Moral obligations can arise from
  – Capability
  – Proximity
  – Degree of need
  – Absence of other sources of aid

• Non-discrimination
  – Cannot refuse care of infected patients (e.g., ADA)
Duty ↔ Heroism ↔ Martyrdom ↔ Stupidity

• What are the limits of the DTT?
  – No absolute universal threshold
  – Continue caring for other patients
  – Reciprocal social obligations
    • Provide PPE, vaccination …
    • Care for those who become ill
    • Reduce other barriers
      – Address liability/other costs
Ethics and Disaster Response

• The Three R’s
  – Responsibility to care despite personal risk
    • The professional “Duty to Treat”
  – Restrictions on liberty
    • Quarantine, isolation and social distancing
  – Resource allocation dilemmas
    • Rationing and crisis standards of care
Encouraging Volunteers: Workers’ Compensation

- May depend upon responder status as employee or volunteer
- In some states, volunteers defined as state employees during disasters
- If temporary employees, volunteers may be eligible for benefits from the institution for which they are volunteering
Encouraging Volunteers: Regulatory Issues

• State
  – Licensure & credentialing
  – Waivers of licensure in declared disasters
    • Emergency Management Assistance Compact
    • UEVHPA
    • Medical Reserve Corps

• Federal
  – Federal health care providers (uniformed services, VA)
  – Federalized health care providers (DMAT)
Encouraging Volunteers: Civil & Criminal Liability

- Criminal liability: no immunity
- Civil liability immunity
  - Mutual aid compacts
  - Good Samaritan statutes
  - State emergency health powers statutes
  - UEVHPA
  - Federalized providers
- Gaps remain in liability protection for responders
Uniform Emergency Volunteer Health Practitioner Act

• Triggered by state or local declaration of emergency
  – Licensure reciprocity
  – Immunity from liability
  – Workers’ compensation benefits

• Requires volunteers to be registered with an authorized registration system

• Not for volunteers paid through pre-existing employment agreement

• Adopted by 12 states as of 2011
Encouraging Organized and Trained Volunteers

😊 Team response

– Registered volunteers (ESAR-VHP, MRC)
– Affiliated volunteers (Red Cross)
– Federal level (DHHS Temporary, DMAT)

😢 Spontaneous volunteers = “mass provider incident”
II. Restrictions on Liberty

• Quarantine
  – Separation or restriction of movement of healthy persons exposed or potentially exposed

• Isolation
  – Separation of those known to be ill or infected

• Social distancing
  – Closure of schools, games, churches, events, etc. to reduce risk of exposure
Waiver of Certain Federal Rights

• Conditions: President declares emergency & HHS Secretary declares PH emergency

• May be waived for 72 hours
  – Emergency Medical Treatment & Active Labor Act (EMTALA)
  – HIPAA privacy rule

• Applicable within period of emergency to emergency area & disaster-activated hospitals
Ethical Issues Seem Stark

The ethos of public health and that of civil liberties are radically distinct.
Bayer 1991

• Yet
  – “Voluntarist consensus” around HIV
  – Restriction attempts can backfire
U.N. Siracusa Principles

• Coercive public health measures must be
  – Legitimate
  – Legal
  – Necessary
  – Non-discriminatory
  – “Least restrictive means appropriate to the reasonable achievement of public health goals.”

• Consider also reciprocity, transparency and accountability/due process.
Ethical Questions *Predicated On*...

- J.S. Mill’s “harm principle”
  - “...the only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others.”
  - *On Liberty*, 1859

- Ethical dilemma IFF the proposed restriction actually prevents harm to others
  - *First task is to assess effectiveness*
Effectiveness Can Depend On …

- Social characteristics
  - Social cohesiveness, trust and knowledge
  - Social groups affected
- Biological factors
  - Transmissibility
  - Duration
  - Recovery rate
  - Correlations of symptoms and infectiousness
Mixed Evidence of Effectiveness

• Some experiences suggest little utility
  – *There is no force on earth that can make Americans do something that they do not believe is in their own best interest and that of their families.*
    • Sen. Sam Nunn

• Some evidence quarantine can backfire
  – *Officials in Taiwan now believe that its aggressive use of quarantine contributed to public panic.*
    Rothstein et al, 2003
Mixed Evidence of Effectiveness

• Mathematical models suggest sometimes even “leaky” quarantine can work, can smooth the epidemic curve

• Relatively high public acceptance (in theory)

• Must be compared to alternative strategies, such as mass screenings:
  – China screened 14 million travelers for SARS: 12 cases
  – Toronto screened > 1m: 0 cases
  – Some SARS cases in China were linked to exposures while standing in line, waiting to be screened
Restrictive Measures Always Used in Combination

- Screenings
- Vaccination
- Contact tracing
- Masks
- Social distancing
  - “Snow days”
  - Cancellations of public events
  - Closing public venues (swimming pools)
  - Telecommuting
- Quarantine
- Isolation
Respect the Sacrifices of Those Under Quarantine

• Job protection
  – 20%: employer would force them to work ill
• Family duties: kids, parents, pets
• Priority, rapid treatment
  – Fears of overcrowding and exposure to illness
• Stigma, discrimination, privacy
• Social isolation
  – Symptoms of PTSD in ~1/3rd quarantined
It is a canard sometimes used to justify authoritarian actions that the public responds to emergencies by losing control and panicking; indeed, it is the consensus of social scientists that people in emergency situations tend to be more cooperative and more generous toward others than they may normally be.

– Edelson, 2006
Who Panics, Who Protects?

- Panic among the public is rare
- But political leaders might seek to be seen as responding aggressively to threats
- Special obligations of health professionals to guard against pressure for inappropriate (and counterproductive) uses of police powers in crisis
III. Resource Allocation

New York seniors waiting for flu vaccine
Photograph by Mario Tama/Getty Images
Unlike in usual practice, the only priority in a disaster is to save the most lives

A. Yes. Medical ethics should become purely utilitarian during emergencies

B. No. Medical ethics remains fundamentally the same in emergencies, despite the altered context

C. Maybe. Medical ethics is vague and depends mostly on your personal underlying beliefs
Suggested Principles to Guide Rationing

• Save the most lives: highest risk first
• Save the most *life years*: youngest first
• Save the most *productive/quality* life years
• Women and children first
• First come, first served
• Market-based
“Fair Innings” or “Life Cycle Allocation”

There is great value in being able to pass through each life stage – to be a child, a young adult, and then to develop a career and family, and to grow old.

Emanuel and Wertheimer, 2006
Other Values Often Considered

- Necessity: Is rationing necessary?
- Compassion: Protecting the vulnerable
- Equity: Promoting social justice
- Efficiency: Maintaining social order
- Value: Minimizing economic impact
- Social Trust: Maintaining a good society
- Respect: E.g., For the dying
Standard of Care

- Legal and ethical obligation is to perform to highest standard a reasonable practitioner can achieve under given circumstances
  - i.e., standard of care always depends on context
- Disaster context ≠ normal routine
- It can be impossible to attain usual levels of quality/operations when resources unavailable
  - Joint Commission: aim is “graceful degradation”
Drawing lines in a granular world

Resources

- **Supplies**
  - Conservation/use of alt. meds
  - All usual beds full/reserve beds activated and filled

- **Space**
  - Emergency stockpiles accessed
  - All in-place/reserve beds activated and filled
  - All facility areas (hallways, etc) in use and filled
  - Generally unsafe to be on site

- **Staffing**
  - Reserve staff needed
  - External staff needed
  - Staff must perform atypical tasks
  - Lay volunteers must perform key aspects of care

Capacity (operational quality)

- **Usual Ops**
  - Usual Quality
  - Minimal/transient degraded quality

- **Contingency Ops**
  - Modest/brief degraded quality

- **Crisis Ops**
  - Significant/ongoing degraded quality

- **Catastrophic failure**
  - No care possible

- **Supplies unavailable/unusable**
- **Infrastructure destroyed**
- **Few/no staff available**
“Crisis Standards of Care”

• Defined by IOM as:

  A *substantial* change in usual health care operations and the level of care it is possible to deliver, which is *made necessary* by a pervasive (e.g. pandemic influenza) or catastrophic (e.g. earthquake, hurricane) disaster.

  – *Justified* by specific circumstances
  – Formally *declared* by a state government
  – *Sustained* period or altered operations
  – *Enables* specific powers and protections
IOM Vision for Crisis Care

• Fairness – recognized as fair by all
• Equitable processes
  – Transparency
  – Consistency
  – Proportionality
  – Accountability
• Participatory engagement
• Governed by rule of law
  – Authority
  – Appropriate legal environment
IOM Ethical Framework

As a starting point consider the following

- Substantive Norms ("ethical norms")
  - Fairness
  - Duty to Care
  - Duty to Steward Shared Resources

- Procedural Norms ("ethical process")
  - Transparency
  - Consistency
  - Proportionality
  - Accountability

Each community may elicit more
Core Ethical Challenge

• Injury & illness >> resources
  – Patient A is on a ventilator, Patient B also needs it…
    • Withdrawal of care ≠ euthanasia
    • Palliative care ≠ euthanasia
    • Expectant care ≠ euthanasia

• Deep discomfort, but *forced choice*
AMA-ANA joint statement

• Very concerned about criminalizing decisions about patient care…when medical personnel & supplies are severely compromised

• During any disaster, health care providers—doctors, nurses, & others—work together to make best decisions given available resources

• Criminal prosecution fosters fear of having best judgments second-guessed in disasters
Resource Allocation Summary

- Use limited resources fairly
  - Achieve greatest benefit
  - Preserve ethical obligations
  - *Comfort always*

- Decision making should be
  - Based on good situational awareness
  - Transparent
  - Consistent
  - Proportionate
  - Accountable

- **Avoid** ad hoc decisions by individuals
Summary

• State & federal response to disasters must be tiered and coordinated

• Responsibilities of all professionals to be prepared and care during crises

• Restrictions on liberty implemented with good data and great caution

• Resource allocation decisions can be heart-wrenching, yet consistent with medical ethics
  – Standard of care always depends on context
  – Decisions should be transparent, well-informed and consistent, not \textit{ad hoc}
What Questions Do You Have?
In the last 6 months, an apparently contagious and deadly infectious illness has been detected worldwide, mostly among blue-eyed people. Up to 20% of some communities might already be infected. There is no known treatment, it seems to be spread sexually, and some non-blue-eyed people have been infected. Screening tests for the illness are ~70% sensitive and 90% specific. Tinted contact lens sales are soaring.

For Discussion
- Country A: Plans voluntary mass screening for the illness and a campaign urging “safe sex” or abstinence for blue-eyed people
- Country B: Plans eye color screening of arriving travelers and refusal of blue-eyed visitors.
- Country C: Plans military quarantine of all blue-eyed people in detention camps until greater clarity on screening, modes of transmission and treatment can be obtained
Discussion Case –
Allocation of Operative Care

• You are 6 weeks into a pandemic influenza and the health care system is taxed beyond capacity – all hospital beds and ventilators are in use and practitioners are working extended shifts. Elective operations have been delayed for the last 2 weeks.

For Discussion

– Hospital A: Critical care as usual; first come, first served
– Hospital B: Key interventions only for those expected to survive >6 months

Adapted from Levin, Cadigan, Biddinger et al. 
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