An Ethical Disaster:
How Health Care Professionals
May React Ethically in a Disaster

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Alabama Department of Public Health, 2009

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An Ethical Disaster and Public Health
How Practitioners May React Ethically in a Disaster
By John R. Wible[1]

I. Introduction

If you were on the committee helping to make the answers, what would you say and how would you justify your conclusions knowing that because of what you say, some will live and some will die. Would it help you to make these decisions *ethically*?

The impact of Hurricanes Katrina and Rita on New Orleans, the Mississippi Gulf Coast, Bayou La Batre, Alabama and other coastal areas was the "largest natural disaster in U.S. history." [2] Thousands of health care personnel and their families were stranded in New Orleans or evacuated perhaps never to return.

The decision to come home or to take up life in a new city or state may be influenced by many reasons personal to each person, however much of the influence on these folk is due to the psychological traumas experienced as a result of the ethically perpetuated conflicts with which they were forced to contend, in some instances.[3] That has already happened – and it was not only a disaster for the people, but for the public health professionals who served them as well. That disaster – what was – raises serious ethical questions that are the subject of this work. The disaster that was . . .

And now, **CDC** tells us:

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[1] General Counsel, Alabama Department of Public Health. The writer acknowledges the assistance of Joseph Ali, University of Pittsburgh Law School; Dr. John Reese, USAF ACSC; and Kathy Vincent and Frances Kennamer, Alabama Department of Public Health for their review and assistance herein.

[2] Government Accounting Office. GAO 06-808T, May 25, 2006.

[3] Yolanda M. Powell-Young, Assistant Professor, Dillard University Division of Nursing, New Orleans, Louisiana; Janelle R. Baker, Associate Professor of Nursing, Florida A & M University School of Nursing, Tallahassee, Florida and Jacqueline G. Hogan, Administrative Supervisor, Touro Infirmary, New Orleans,

> Influenza viruses have threatened the health of animal and human populations for centuries. A pandemic occurs when a novel strain of influenza virus emerges that has the ability to infect and be passed between humans. Because humans lack immunity to the new virus, a worldwide epidemic, or pandemic, can ensue. Three human influenza pandemics occurred in the 20th century. In the U.S., each pandemic led to illness in approximately 30 percent of the population and death in between 2 in 100 and 2 in 1,000 of those infected. It is projected that a modern pandemic, absent effective control measures, could result in the deaths of 200,000 to 2 million people in the United States alone.
> . . . However, at the beginning of a pandemic, the scarcity of pre-pandemic influenza vaccine and pandemic influenza vaccine (which could include up to two doses) will require that the limited supply be prioritized for distribution and administration.
>
> . . . Accordingly, the Federal government has initiated a process to provide guidance to assist State and local governments, communities, tribal and territorial governments, and the private sector in defining groups that should be considered for priority access to scarce vaccine.
>
> . . . With this RFI, the Department of Health and Human Services (HHS) requests input from the public on considerations in developing guidance for prioritization of the distribution and administration of both pre-pandemic and pandemic influenza vaccines based on various pandemic severity and vaccine supply scenarios. [4]

And **CDC** asked us to answer these questions:

- What objectives, principles, strategies, criteria, assumptions and rationales should be considered in pandemic vaccine prioritization determinations?
- What is the relative importance of the three goals described above and what are the associated implications for vaccine prioritization?
- Which population group(s) should have priority for receiving pre-pandemic vaccine?
- Which should have priority for receiving pandemic vaccine?
- What is the rationale?
- How can fairness, equity, efficiency and related principles be reflected in the determination of priority groupings for receipt of pre-pandemic or pandemic vaccine?
- For priority groups, how should vaccine be allocated, distributed and administered?
- Who (Federal, State or local authorities) should determine when and how the vaccine is distributed and administered?

(From the previous page) Louisiana . "Disaster Ethics, Health care and Nursing: A Model Case Study to Facilitate the Decision Making Process."

4 Federal Register: December 14, 2006 (Volume 71, Number 240)[Notices] [Page 75252-75253]

If you were on the committee[5] helping to make the answers, what would you say and how would you justify your conclusions knowing that because of what you say, some will live and some will die. Would it help you to make these decisions *ethically*?

An Ethical Person - How many of you think of yourself as an "ethical person?" Upon what is your belief based? Who exceeded the speed limit on the way to this week's activities? Why, don't you think speed limits are important? Are you above the law? Why do you think they have speed limits?

From where do ethics come? From where do our personal ethics come? (From "your Mama.") The poet, Robert Fulghum [6] tells us:

> *Most of what I really need to know about how to live, and what to do, and how to be, I learned in kindergarten. Wisdom was not at the top of the graduate school mountain, but there in the sand box at nursery school.*
>
> *These are the things I learned. Share everything. Play fair. Don't hit people. Put things back where you found them. Clean up your own mess. Don't take things that aren't yours. Say you are sorry when you hurt somebody. Wash your hands before you eat. Flush. Warm cookies and cold milk are good for you. Live a balanced life. Learn some and think some and draw some and paint and sing and dance and play and work everyday.*
>
> *Take a nap every afternoon. When you go out in the world, watch for traffic, hold hands, and stick together. Be aware of wonder. Remember the little seed in the plastic cup? The roots go down and the plant goes up and nobody really knows how or why. We are like that.*
>
> *And then remember that book about Dick and Jane and the first word you learned, the biggest word of all: LOOK! Everything you need to know is there somewhere. The Golden Rule and love and basic sanitation, ecology, and politics and the sane living.*
>
> *Think of what a better world it would be if we all, the whole world, had cookies and milk about 3 o'clock every afternoon and then lay down with our blankets for a nap. Or we had a basic policy in our nation and other nations to always put things back where we found them and clean up our own messes. And it is still true, no matter how old you are, when you go out in the world, it is best to hold hands and stick together.*

---

[5] In the influenza pandemic of 1917-1918, the City of Seattle established a committee of experts to help make critical decisions. Since their decisions were literally life and death, they became known pejoratively as the "God Committee."

6 *Robert Fulghum,* All I Ever Needed to Know, I Learned in Kindergarten.

Behaviorists tell us that this is basically true. We learn or inherit our ethical principles, (depending on your viewpoint) when we are young children. By the time we are grown up, they are basically set. They can be changed a bit, but mostly just controlled or coped.

See if you can discover the secret. (Hint: the secret's in the sauce.)

Purpose of the Paper - The purpose of this paper is to ask you a lot of questions and help you discover the answers from within yourself so that ultimately, you will be able to make decisions from *within* enabling you to go about living *outside* yourself.[7] Beyond this, there is a secret – "the secret's in the sauce."[8] See if you can discover it.

Ethical Lines - We each have ethical boundaries, lines that we will not cross or will not cross except with great stress. This is an application of the famous "80-20 Rule." It is said that 20 percent of people are on the margins. Ten percent will basically never act in a manner contrary to their ethical principles. Some of these are religious, some are not. The other ten percent of people basically have few ethical principles or their ethical principles are so shaded toward personal gain that effectively, they have no ethical principles when compared to those of society in general. [9]Obviously, many of these are criminals that have or will be imprisoned at some time in their lives. The other 80 percent of the population are principled people can be led for good or evil to do right or wrong.

[7] "Living outside yourself" is a concept which will be more fully developed *infra.*

[8] "The secret's in the sauce," from *Fried Green Tomatoes at the Whistlestop Cafe*, (1987) by the Alabama writer, Fannie Flagg.

[9] This is an application of "Pareto's Principle." In 1906, Italian economist Vilfredo Pareto created a mathematical formula to describe the unequal distribution of wealth in his country, observing that twenty percent of the people owned eighty percent of the wealth. In the late 1940s, Dr. Joseph M. Juran inaccurately attributed the 80/20 Rule to Pareto, calling it Pareto's Principle. See: Arthur W. Hafner, Ball State University, 2001, "Pareto's Principle: The 80-20 Rule" and Schmidt, Stephen, "Towards Teaching a Normative Ethics: Or, Ethics Even an Economist Can Accept" (July 2006). Available at SSRN: http://ssrn.com/abstract=921294

Business Ethics – Robert Fulgum notwithstanding, a study of workers indicated to business ethicists that the greatest influence on them *on the job* was their immediate supervisor who set the example and charted the course for them at work.[10] That having been said, business ethicists tell us that the job of a boss or manager is not to teach ethics to his or her employees, but to learn which employees will react ethically in a given situation and try to place employees in a position to succeed rather than to fail.

We don't have to volitionally teach ethics, just like we learned it from our mothers, employees learn from supervisors by observation.

Personal Questions: Since we all claim to be ethical persons, may I ask:

- Who helped shape your ethical principles and how?
- What did he or she teach you?
- What do you think is the most important ethical principle of them all and why?

Basic ethical concepts questions - For our purposes, I propose to ask some rhetorical basic ethical questions that I believe will lead you toward acting ethically in a world that is increasingly more "ethically challenged."[11]

- What are some universally accepted ethical concepts?
- From where did they come and how do we learn them as individuals?
- How does each of us develop his or her own set of ethical principles?
- Do we view those as static or sliding?
- What is the price of each of us? (For how much would you sell out?)

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[10] According to Professor William I. Sauser, Jr., Ph.D., Auburn University.

[11] Ragavan, Chitra, *Ethically Challenged Corruption plagues the Hill, but don't expect much reform U.S.* News and World Report, May 22, 2006.

II. John's Five Action Principles

Tell the truth
Sing - Sunshine
Casper
Not About Me
Nike

With apologies to Thomas Aquinas and Immanuel Kant for even writing these thoughts in the same paragraph in which theirs are noted, I would nevertheless submit that behaving ethically may be summed up in five action principles, which have as their core, the concept that there is absolute truth. Truth is not relative, though our exercise *of* truth or our exercise *in* truth may change according to circumstance.[12] Everybody doesn't believe this. It particularly doesn't play well in a relativist society.[13] This is why we are so hurried, insecure and conflicted.

- "**To Tell the Truth, the Whole Truth and Nothing but the Truth**"[14] -We must first study and learn the absolute truths and never vary from them. We have to keep reminding ourselves of the truths because as the Qur'an reminds us, "we forget."[15] If we devote our total allegiance to the truth, we will be free to make ethical decisions without fear of making a mistake, (not without making mistakes, but without *fear* of making mistakes) and without fear of the consequences because, if we have followed the truth, *we* are not responsible for the consequences, the *truth* is responsible for the consequences. It is when we do not follow the truth, that we transfer the responsibility for failure to ourselves.

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[12] See T. d'Aquino, *Summa theologiae*.

[13] See Immanuel Kant, *The Critique of Pure Reason (Kritik der reinen Vernunft),* first published in 1781 with a second edition in 1787. *Critique* is often referred to as Kant's "first critique", and was followed by the Critique of Practical Reason and the Critique of Judgment.

[14] From: The Witness' Oath.

[15] "Our Lord! Take us not to task if we forget or fall into error." (Qur'an, 2:286)

- "*Absolutely, Mr. Pitney – positively, Mr. Bowes.*" [16] There is absolute truth. In the planning process, there are certain rules, facts and principles that will have to be applied. It is your duty to know these "truths" before you start planning.
- *The "No Delta Principle"*- Ethical principles do not change no matter the situation, only the application of them. Moral Relativism is a myth.[17]
- "*Free at last, free at last!*" [18]You will know the truth and the truth shall make you free.[19] See the earlier discussion about reliance upon the truth as it relates to the placement of responsibility for the outcome.
- *"Be a Square"* - In the storm, we make our decisions by applying the plumb line[20] and level of the truth. In so doing, our decisions, while not popular, while perhaps even fatal to some and while perhaps even fatal to ourselves or to our career, [21] nevertheless are square. We in public health are public servants, our career is serving the public. If we don't believe that, perhaps we need to get another job.

- **"We'll Sing in the Sunshine"**[22] - To the extent practicable, we pre-plan disaster decisions in the sunshine. This proves the old joke: "when we are up to our

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[16] From the 1980s TV commercial for Pitney-Bowes Office Machines, based on the classic 1920s vaudeville act of Ed Gallagher and Al Shean – "Positively, Mr. Gallagher, absolutely, Mr. Shean."
[17] More apologies to Kant. But we also cross swords on this point with David Hume, Jean-Jacques Rousseau, Nietzsche and Karl Marx.
[18] Dr. Martin Luther King from the "I have a Dream" speech delivered at the Lincoln Memorial in Washington, D.C., August 28, 1963.
[19] John 8:32.
[20] See Amos 7:7,8.
[21] Dr. Donald E. Williamson, Alabama State Health Officer is fond of saying that in each public health senior manager's life there may come a time when he or she will have to make a "career ending decision."
[22] From the song of the same name by Gale Garnett.

eyeballs in alligators, it's hard to remember that our original plan was to drain the swamp." You can't plan in the middle of a swamp. To fail to do this is to shirk our duty and itself is a moral failing as leaders of this society.

- **"Casper the Friendly Ghost,©"** [23] – Transparency and accountability are twins.
    - *"You're a pane"* -Transparency - To the extent possible, decisions should be made not only in the sunshine temporally, by also visually and influentially as well. A transparent decision making process is a huge asset to accountability and an aide to good decision-making. [24] To the contrary, a non-transparent decision making process has the potential to give us a situation that can account for one of the greatest moral failures in US history, the election of 1876 resulting in the naming as president, President Rutherford B. Hayes. [25]
    - "*No Accountability Vacuum."* No matter how well intentioned we start out, if there is an accountability vacuum, we are strongly tempted to cut corners. One thing leads to another and eventually, we create our own

[23] Created by Joe Oriolo and Sy Reit in 1945, Casper first appeared in the Paramount/Famous Studios animated cartoon, "The Friendly Ghost". He went through a series of 55 theatrical cartoons and was the studio's biggest animated star after Popeye. Currently licensed by Harvey and Marvel Comics.

[24] See Seidman, Dov, *How – Why HOW We Do What We Do Means Everything*, John Wiley and Sons, Inc., 2007 at page 35.

[25] Until the election of 2000, the election of 1876 was the most disputed US history. Samuel J. Tilden of New York bested Ohio's Rutherford Hayes in the popular vote with a number of electoral uncounted. There was complete stalemate and a congressional committee was appointed to work out a settlement. Many historians believe that a deal was made to resolve the dispute, "the Compromise of 1877". In the deal, the election was stolen, in the view of Northern sympathizing historians. In return for Southern acquiescence in Hayes' election, the Republicans agreed to withdraw federal troops from the South, effectively ending Reconstruction. The Compromise effectively pushed African-Americans out of power in the government; soon after the compromise, African-Americans were barred from voting by poll taxes and grandfather clauses. Many accounts have the deal being made not in the halls of congress where it could be watched and studied, but in the back room of either the Washington's Wormley Hotel or the Fifth Avenue Hotel in New York. For competing views of this see: Morris, Roy, Jr., Fraud Of The Century: Rutherford B. Hayes, Samuel Tilden And The Stolen Election Of 1876, 2004 and Woodward, C. Vann, Reunion and Reaction: The Compromise of 1877 and the End of Reconstruction, 1951.

disastrous failure. The lack of accountability even at the United Nations led to a crisis of leadership and the departure of the Secretary General under a cloud of suspicion and distrust. [26] Where there is no vacuum, the competing pressures of doing good and doing evil stay in balance and a good decision can be made.

- **"It's Not About Me."** [27]We need to adopt the idea that life is not about me. That frees us from worrying about ourselves and frees us to make these plumb and square decisions. To the extent that I am worrying about me, I will be hindered in right thinking and proper decision-making. Evidence the movie, "Air Force One.[28]" In the movie, the President is kidnapped aboard the plane of the same name. While he escapes on-board and talks to the Cabinet in session via a cell phone, there is much speculation among the cabinet that he is under the duress of himself and his family being held captive, thus presumed incapable of making a rational decision.
- **The Nike ® Principle –** We are all familiar with Nike's famous slogan, "*Just Do It.! ®"* But there are other aspects as important as "just doing it."
    - *Just do it NOW.* Resist the urge to procrastinate. To put it off is a virtual guarantee that it will never be done. [29]
    - *Focus, Please.* The danger with "just doing it," is that one can become like a charging rhinoceros. Conservationalists will tell you that the bad thing about a

[26] See Lederer, Edith M., "Annan to Improve UN Accountability," Associated Press, January 31, 2005.
[27] From the book, *It's Not About me: Rescue from the Life We Thought Would Make us Happy* by Max Lucado, Thomas Nelson Publishers, 2004.
[28] "Air Force One," released by Sony Pictures was a 1997 action film starring Harrison Ford and Gary Oldman and was directed by Wolfgang Petersen and released on June 25, 1997.
[29] "Never put off until tomorrow that which can be done today" – your Mother.

charging rhinoceros is that if he runs you down, you're probably dead. The good thing, however is that while his horn is big, his brain isn't and he easily forgets why he was charging and loses focus. In our hurry to "just do it," we can become a charging rhinoceros – and as Martha Stewart might say, "That's a *bad* thing." When dealing with these complex and explosive issues and particularity with other people who have agenda of their own, it requires great focus to "keep the main thing – the main thing."[30]

- *Truth or Consequences.* [31] Everything we do has consequences. We must be aware of that fact and must be aware of the "Law of Unintended Consequences." [32] However, perhaps the greater danger for the government planner is not that he or she doesn't think through the possible consequences, but rather that he so *overthinks* the consequences that he is paralyzed in the decision-making process. Hence, back to the main bullet – *Just Do It!*

III. An Ethical Problem

The Problem - The Great Pandemic of 2000-whatever is raging. Imagine that you are Dr. Mark Craig, the CEO of Saint Elsewhere and you are attempting to cope with this disaster unfolding before your eyes. It plays out in a million stories, but one of them presents you with a series of choices to make that will affect the lives of people and

[30] Attributed to Stephen R. Covey.
[31] From the NBC radio and TV program of the same name, immortalized by the legendary Bob Barker.
[32] The Idea dates to the Scottish Enlightenment and consequentialism, or judging by results. In the twentieth century, sociologist Robert K. Merton once again popularized the concept, sometimes referred to as the Law of Unforeseen Consequences. Merton (1936) spoke of the "unanticipated consequences" of "purposive social action", emphasizing that his term "purposive action… [is exclusively] concerned with 'conduct' as distinct from 'behavior.' That is, with action that involves motives and consequently a choice between various alternatives." See "The Unanticipated Consequences of Purposive Social Action" by Robert K. Merton, American Sociological Review, Vol. 1 Issue 6, Dec 1936, pp.894-904.

probably your career. The characters below show up at Saint Elsewhere, the county's only general hospital. They have symptoms consistent with the raging pandemic flu. Resources and staff are past the breaking point. There are two general questions that you must answer about triage and staff participation: who gets what and when and how to keep staff?

- Triage:
    - How will hospitals sort patients to determine priority for treatment?
    - What criteria will be used?
    - Who will develop those criteria?
- Staff Participation: Are healthcare workers obligated to work during an influenza pandemic?
    - What can be done to increase staff participation
- Characters:
    - Annie Cavanero: female, age 18, recent high school graduate. Miss Cavanero was the salutatorian of her senior class; she plans to attend The University of Pennsylvania in the fall and major in history.
    - Cathy Martin: female, age 64, registered nurse. Mrs. Martin has been employed at your hospital for 14 years.
    - Ben Samuels: male, age 23, bus boy at local restaurant. Mr. Samuels suffers from a moderate form of autism; however, he did complete high school and plans to attend college in the fall.
    - Wayne Fiscus: male, age 61, police officer. Mr. Fiscus plans to retire from the police force in the next 4 years.

- Unknown: male, age 42. This homeless man was found in an abandoned building; he apparently was attempting to care for 3 other homeless individuals who were suffering from the flu as well.
- Peter White: male, age 52, janitor at your hospital. Mr. White has worked in the maintenance department of your hospital for 29 years; he is the president of the hospital's maintenance facility workers' union.
- Helen Rosenthal: female, age 86, retired journalist. Mrs. Rosenthal and her husband are holocaust survivors; she and he give between 10 and 20 lectures each year about their experience in a concentration camp.

IV. Sources of Personal Ethical Principles

- Ancient Greece
- Religious Teachings
- The Declaration of Independence and The United States Constitution

Ancient Greece

Our personal ethics are drawn from our background and the principles we learned at home, be they religious in origin or not. We are influenced by our culture in great degree. Ancient Greece birthed Western philosophical ethics. Whitehead stated: "The safest general characterization of the European philosophical tradition is that it consists of a series of footnotes to Plato."[33] Socrates, Plato, and Aristotle, who lived in the 5th and 4th centuries BC, are perhaps best known to us, but they were not the first Greeks to considered ethical problems. Earlier poetic literature laid the foundation for their ideas.[34]

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[33] Alfred North Whitehead, Process and Reality, p. 39 (Free Press, 1979)

[34] International World History Project, World History From The Pre-Sumerian Period To The Present: A Collection Of World History Related Essays, Documents, Maps and Music. "A History of Ancient Greece - The Glory That Was Greece," Robert A. Guisepi. (2001). http://history-world.org/ancient_greece_and_ethics.htm Accessed November 15, 2008.

Plato and Aristotle quoted the most prominent of the earliest ethical philosophers, known as the "Seven Sages." [35]

Socrates' ethical philosophy is summarized in the phrase, "know thyself." He taught that in truly knowing yourself, you could really discern what was "good." Plato argues that human well-being is the highest aim of moral thought and conduct. He believed that these were learned skills and one should study the sciences and philosophy to improve one's knowledge of "the good." Aristotle's approach was more practical, urging that we apply our concepts of courage, justice, temperance and the other virtues in social settings and hone the skills based on the social interplay.

Religious Teachings

Certainly, religious teachings have had an incalculable effect on the ethical conduct of men and women. It probably does an injustice to pass over as summarily as we must in this brief course the plenary teachings of the great religious leaders through the millennia, but we can take a quick snap shot of them.

Hindu - [36] The oldest extant religion is certainly Hindu. In Hindu thought, the Sanskrit term "Dharma" refers to the underlying order in Nature and human life and behavior considered to be in accord with that order. Ethically, it means "right way of living" or "proper conduct," especially in a religious sense. Dharma is a central concept in religions and philosophies originating in India. These religions and philosophies are called Dharmic religions. The principal ones are Hinduism (Sanatana Dharma),

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[35] Thales of Miletus,, Pittacus of Mytilene, Bias of Priene, Solon, Cleobulus of Lindus, Myson of Chen, and Chilon of Sparta according to Plato quoting Socrates.

[36] See Dr. Pandurang Vaman Kane, *History of Dharmasastra* subtitled *Ancient and Mediaeval Religions and Civil Law in India.* This work researched the evolution of code of conduct in ancient and mediaeval

Buddhism (Buddhadharma), Jainism (Jain Dharma) and Sikhism, all of which emphasize Dharma (the correct understanding of Nature) in their teachings. In these traditions, beings that live in accordance with Dharma proceed more quickly toward personal liberation.

In the traditional Hindu society based on its caste structure, Dharma constituted the religious and moral doctrine of the rights and duties of each individual.

The voluminous Hindu writings are primarily a product of the Brahmanical tradition in India and represent the elaborate scholastic system of an expert tradition. The Dharma is important within the Hindu tradition--first, as a source of religious law describing the life of an ideal householder and, second, as a symbol of the summation of Hindu knowledge about religion, law, ethics, and many other things.

The writings have been divided into three major topics:

- Acara - rules pertaining to daily rituals, life-cycle cites, and other duties of four castes or varnas,
- Vyavahara - rules pertaining to the procedures for resolving doubts about dharma and rules of substantive law categorized according the standard eighteen titles of Hindu law, and
- Prayascitta - rules, expiations and penances for violations of the rules of dharma.

In the yoga tradition of Hindu, its founder, Panta[illegible]jali (200BC) discussed what he called the “8 Fold Path” which he pictures as a woman with eight arms circling her.

India by looking into several texts and manuscripts compiled over the centuries. It was published in 5 volumes; the 1st volume was published in 1930 and the last, in 1962.

Two of the arms deal with morals: Yamas, which are the five moral restraints and Niyamas, the five moral observances. [37]

Yamas – Moral Restraints		**Niyamas – Moral observances**	
Ahimsa	- do no harm	Saucha	- cleanliness
Satya	- do not lie	Samtosha	- contentedness
Asteya	- do not steal	Tapas	- perserverance
Brahmacharya	- moderation	Svahhyaya	- self-study
Aparigraha	- do not hoard	Ishvara pranidhana	- surrender to the higher being

Dharma also refers to the teachings and doctrines of the founders of these traditions, such as those of Gautama Buddha and Mahavira.

Buddhism – In Buddhism, any person who has awakened from the "sleep of ignorance" by directly realizing the true nature of reality is called a "buddha." Siddhartha Gautama, the Buddha, is the most notable but only one among other buddhas before or after him. His teachings are oriented toward the attainment of this kind of awakening, also called enlightenment, Bodhi, liberation, or "Nirvana."

Part of the Buddha's teachings regarding the holy life and the goal of liberation is constituted by the "The Four Noble Truths," [38]which focus on suffering or the sorrow of life. The Four Noble Truths regarding suffering state what is its nature, its cause, its cessation, and the way leading to its cessation. This way to the cessation of suffering is called "The Noble Eightfold Path," which is one of the fundamentals of Buddhist virtuous or moral life.

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[37] Charles Johnston, ed. *The Yoga Sutras of Patañjali: the Book of the Spiritual Man by Patañjali*. Project Gutenberg, 2001.

[38] Thanissaro Bhikkhu, *Wings to Awakening An Anthology from the Pali Canon*. (Valley Center, CA. 1996)

The Noble Eightfold Path is the way to the cessation of suffering, the fourth part of the Four Noble Truths. This is divided into three sections: Sila (which concerns the physical bodily actions), Samadhi (which concerns the 'Conscious' mind) and Panna (which concerns the 'Unconscious' mind). For our ethical study purposes**,** Sila is morality—abstaining from unwholesome deeds of body and speech. Within the division of Sila are three parts of the Noble Eightfold Path: [39]

- Right Speech - One speaks in a non-hurtful, not exaggerated, truthful way;
- Right Actions - Wholesome action, avoiding action that would do; and
- Right Livelihood - One's way of livelihood does not harm in any way oneself or others; directly or indirectly. Within this division are another three parts of the Noble Eightfold Path:
    - Right Effort/Exercise - One makes an effort to improve;
    - Right Mindfulness/Awareness - Mental ability to see things for what they are with clear consciousness; and
    - Right Concentration - Being aware of the present reality within oneself, without any craving or aversion. Within this division fall two more parts of the Noble Eightfold Path: Right Thoughts and Right Understanding.

Judaism. - Moses, (*circa.* 1400-1200 BC) gives us not only the Jewish faith but also the ethical principles which underlie it, the Decalogue. The Ten Commandments, or Ethical Decalogue (as distinguished from the ritual Decalogue), are a list of religious and

[39] Manly P. Hall, *Noble Eightfold Path.* Philosophical Research Society; 7 Rev. Ed. edition (July 1996.)

moral imperatives that, according to the Hebrew Bible, the *Tanakh*[40] were written by God and given to Moses on Mount Sinai in the form of two stone tablets. They feature prominently in Judaism and Christianity, both Catholic and Protestant. The phrase "Ten Commandments" generally refers to the broadly identical passages in Exodus 20:2-17 and Deuteronomy 5:6-21.

The commandments passage in Exodus contains more than ten imperative statements or “Words,” totaling 14 or 15 in all. However, the Bible itself assigns the count of 10. Faiths and denominations have divided these statements in different ways. The table below highlights those differences using the New Revised Standard Version translation. You will note that there are 13 sayings divided in different ways over the years by scholars of the Judaic tradition and the Christian denominations including Protestant and Catholic/Lutheran.

Commandment	**Jewish**	**Protestant**	**Catholic / Lutheran /**
I am your God	1	1	1
You shall have no other gods before Me	2		
You shall not make for yourself an idol		2	
You shall not make wrongful use of the name of your God	3	3	2
Remember the Sabbath and keep it holy	4	4	3
Honor your parents	5	5	4
You shall not murder	6	6	5
You shall not commit adultery	7	7	6
You shall not steal	8	8	7
You shall not bear false witness	9	9	8
You shall not covet your neighbor's wife	10	10	9
You shall not covet your neighbor's house...			10

[40] The *Tanakh*, the acronym formed from the initial Hebrew letters of the Tanakh's three traditional subdivisions, substantially, the *Old Testament* of the Christian Bible.

The Torah, or first five books of the Hebrew Bible have a total of 613 "commandments" [41] and assign no greater value to the Ten Words than the others. These ethical principles have been elaborated on by the rabbinical tradition over the centuries, (or as I have said, "Moses gave us the Law and man wrote the regs.")

Christianity – The ethical teachings of Jesus build on the Judaic concepts of ethical behavior but take the teachings in an internal manner. The greatest portion of Jesus' teaching comes from the so-called "Sermon on the Mount."[42] Jesus states that he did not come to abolish the law, but to fulfill it.[43] Jesus reaffirms the *principles* of the Decalogue and commands strict adherence. [44]

And, in being most critical of the Pharisaic tradition of keeping the "jot and tittle" of the law, but with a bad motive,[45] He tells those seated on the *Horns of Hatten* that their righteousness must exceed that standard. In much of the discourse that follows, Jesus takes a fresh look at the various *words* of the Decalogue and places his spin on them. Their essence, however is that mere adherence to the law is not sufficient. Jesus teaches that man must do more than appear to be righteous, he must *be* righteous. In summary of the Sermon on the Mount, [46]Jesus, through example, admonishes listeners to approach life in two ways: both negatively and positively. When you are done wrong, let it go,

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[41] Kaufmann Kohler and Isaac Broydé , "The 613 Commandments", The Kopelman Foundation, *Jewish Encyclopedia,* 2002.

[42] John Murray, *Principles of Conduct* (1957), Wm. B. Eerdmans Publishing Company; Reissue edition (September 1991).

[43] Matthew 5:17.

[44] Vv.19, 20.

[45] V. 20.

[46] Vv. 38-42.

don't insist on your rights and don't act out of spite.[47] But He goes further, on to the positive telling the reader, rather to be generous to the wrongdoer. The Apostle Paul adds to this, "be not overcome with evil, but overcome evil with the good."[48]

No discussion of the ethical teachings of Jesus would be complete without perhaps His most famous ethical statement found in Matthew 5:43, "Love thy neighbor as thyself." (KJV.) The gospel writer, Luke, perhaps recording this same event has Jesus state, "do unto others as you would have them do unto you."[49]

The teachings of Jesus would seem to go on about love. In fact, they do. In Matthew 22:35-40 (KJV), we find this answer to the question posed by the scribe, perhaps to attempt to trap Jesus or perhaps merely seeking his thoughts on the subject which was one of discussion in the rabbinic tradition of the Jews as to which was the greatest of the commandments.

> *Then one of them, which was a lawyer, asked him a question, tempting him, and saying, Master, which is the great commandment in the law?*
> *Jesus said unto him, Thou shalt love the Lord thy God with all thy heart, and with all thy soul, and with all thy mind. This is the first and great commandment.* [Jesus adds unsolicited, quoting the *Shema*][50] *And the second is like unto it, Thou shalt love thy neighbour as thyself*. [And His summary statement:] *On these two commandments hang all the law and the prophets.*

Thus, the ethical teachings of Christianity as stated by Jesus reaffirms the spirit of the Jewish Ethical Decalogue underlain by the two-edged principle of love. "Love God and love man." How is this expressed in real life? The Apostle John records in John 14:15 Jesus near last word to his Disciples, (NIV) "if you love me, you will obey my

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[47] Ned Bernard Stonehouse. *The Witness of Matthew and Mark to Christ* (Phila., 1944)
[48] Romans 12:167-21.
[49] The statement known as the "Golden Rule" is found at Luke 6:31.
[50] The *Shema*, Deut 6:4-9.

command." That's how Jesus tells them to love God [Jesus having equated Himself with God in the great "I am" sayings peppered throughout the Gospel of John.] How does one love man? By treating him as you would treat yourself.[51]

The Apostle Paul says, to reach God, one must be righteous, but man is not righteous by nature, thus a spiritual dilemma. [52] Paul tells us that it is by taking on the "mind of Christ" [53] that we can be made righteous and thus reach God. Thus the writer's herein concept of "living outside yourself." This principle is the expansion of the "it's not about me" principle. It is a good thing to understand that life is not about yourself, however, to live in such a manner that recognizes this principle and applies it to daily life is "living outside yourself."

Islam – Islam starts in 622, when the Prophet Mohammed migrated to Medina. There, his preaching was accepted and the community-state of Islam emerged. During this early period, Islam became a world religion uniting in itself both the spiritual and temporal aspects of life and seeking to regulate not only the individual's relationship to God (through his conscience), but human relationships in a social setting as well.[54] Thus, there is not only an Islamic religious institution but also an Islamic law, state, and other institutions governing society.

Islamic doctrine, law, and thinking in general are based upon four sources, or fundamental principles: (1) the Qur'an, (2) the *sunnah* ("traditions"), (3) *ijma'*

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[51] See previous note.
[52] Romans 3:23
[53] Philippians 2:5
[54] See **Islam.**" Encyclopædia Britannica. 2007. Encyclopædia Britannica Online. 21 Jan. 2007 <http://www.britannica.com/eb/article-69224>.

("consensus"), and (4) *ijtihad* ("individual thought"). [55] It is said that the Qur'an did not first put forth the ethical principles but merely "reminded" man of their pre-existence.[56] The Qur'an does not tell the reader where the principles were first stated. However, Mohammed thought of himself as the last of the prophets beginning with Abraham and including Jesus. It may well be assumed that Mohammed would have approved their ethical teachings.

The Qur'an (literally, "Reading" or "Recitation") is regarded as the verbatim word, or speech, of God delivered to Muhammad by the angel Gabriel. Divided into 114 *surah*s (chapters) of unequal length, it is the fundamental source of Islamic teaching.

Mohammed, from a semi-nomadic background in Arabia settling in the commercially thriving city of Mecca, became more and more concerned about the changing lifestyle of his Arab brothers – the loss of traditional "tribal values" diminished by the commercial success of the city with its attendant rise in capitalism. [57] He believed that new "cult of self-sufficiency" would mean the disintegration of the tribe, thus he sought to restore the people to the elevated good of the tribe juxtaposed as against the good of the individual: valuing the gain of others more than own one's own gain; deep, strong egalitarianism; taking care of the poor, the orphan and the widow; and indifference to material goods.[58]

Seen against this background, Islam sees as one of its goals, perhaps the chief goal, the ideal of an Islamic social order, a Moslem (faithful) society. The foundation of

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[55] Id.
[56] (Qur'an) Al-Baqarah 2: 188.
[57] Does this sound familiar in our post-modern society?
[58] Karen Armstrong, *A History of God The 4,000 Year Quest of Judaism, Christianity and Islam*. New York, 1993.

Islamic ethics must be understood also in terms of its distinctive and foundational quality. As we have said, Mohammed consciously set out to replace the pagan pre-Islamic ethics with new ideals, so he attempted to establish the following:

- Fraternity/brotherhood in place of blood relationship;
- Fidelity/chastity (certain restrictions in sexual relations) in place of indecency which pagans practiced;
- Humility and charity towards orphans, widows and poor; and
- Justice to neighbors.

While it can be said that many of these ethical demands are typical of the Ancient Near Eastern world, they are generally unique to a moral god, al-Lah.

The ethical response demanded of the Moslem is seen as a *straight path.* In fact, it is said that so clear is this straight path that the ethical way is clearly spelled out by Islam. Thus there is a definitiveness for the believer in Islam; one knows what one ought to do and society is guided by these principles.[59]

American Historical Documents - Declaration of Independence

In Congress, July 4, 1776 - The unanimous Declaration of the thirteen united States of America.

> When *in the Course of human events, it becomes necessary for one people to dissolve the political bands which have connected them with another, and to assume among the powers of the earth, the separate and equal station to which the Laws of Nature and of Nature's God entitle them, a decent respect to the opinions of mankind requires that they should declare the causes which impel them to the separation.*
>
> *We hold these truths to be self-evident, that all men are created equal, that they are endowed by their Creator with certain unalienable Rights, that among these are Life, Liberty and the pursuit of Happiness. That to secure these rights, Governments are instituted among Men, deriving their just Powers from the consent of the governed, — That whenever any Form of Government becomes destructive of these ends, it is the Right of the People to alter or to abolish it, and to institute new Government, laying its foundation on such principles and*

[59] See Dr. Paul F. Jacobs , Professor of Religion, Mississippi State University. "Notes: Religion 3213."

organizing its powers in such form, as to them shall seem most likely to effect their Safety and Happiness. [60]

Perhaps more so than other peoples, Americans are people of the law and thus influenced by the law. United States Supreme Court Justice Anthony Kennedy recently commented[61] on the founding of the United States. He stated that the British were "puzzled" by the colonists' desire to be free. In the British mind, the American colonists were "the freest people in the world." In prophetic and what would become typically American fashion, the colonists answered the puzzlement with a legal document – the Declaration of Independence.

Drafted "largely" by Thomas Jefferson between June 11 and June 28, 1776, the Declaration of Independence is at once the nation's "most cherished symbol of liberty and Jefferson's most enduring monument." Here, in what are referred to as "exalted and unforgettable phrases," Jefferson expressed the convictions in the minds and hearts of the American people. The political philosophy of the Declaration was not new; its ideals of individual liberty had already been expressed by John Locke and the Continental philosophers. What Jefferson did was to summarize this philosophy in "self-evident truths."[62]

It is said that Jefferson was chosen as principal drafter because he had displayed talent as a political philosopher and polemicist in his *A Summary View of the Rights of British America*, published in 1774.

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[60] Documents Illustrative of the Formation of the Union of the American States. Government Printing Office, 1927. House Document No. 398. Selected, Arranged and Indexed by Charles C. Tansill.

[61] CSPAN Television Network – February, 2007.

[62] United States National Archives.

Jefferson wrote the first draft based on the work begun by Thomas Ludwell Lee of Virginia some months earlier. [63] The members of the committee made a number of merely verbal changes [64] and they also expanded somewhat the list of charges against the king. The Congress made more substantial changes, deleting a condemnation of the British people, a reference to “Scotch & foreign mercenaries” (there were Scots in the Congress), and a denunciation of the African slave trade (this being offensive to some Southern and New England delegates). [65]

How interesting it is to note that the founders so eloquently write about the liberty of all mankind only almost, but not quite, condemn slavery as a practice. Jefferson's original draft included a denunciation of the slave trade, which was later edited out by Congress, [66]as was a lengthy criticism of the British people and parliament.[67]

> *He has waged cruel war against human nature itself, violating its most sacred rights of life & liberty in the persons of a distant people who never offended him, captivating & carrying them into slavery in another hemisphere, or to incur miserable death in their transportation thither.*

John Adams, ever the pragmatist, thought and publicly stated that the declaration contained “nothing really novel” in its political philosophy. [68] Jefferson’s theories were

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[63] Thomas Jefferson. An Exhibition of the Library of Congress. (Washington D.C. 2000)

[64] It is interesting to note that Jefferson’s first draft referred to the truths as “sacred and undeniable,” however it was Benjamin Franklin who penned the words, “self-evident.” See Bruce E. Johansen, *Forgotten Founders*, (Ipswich, Mass, 1982) Chapter 6.

[65] United States National Archives.

[66] On the other hand, maybe these egalitarian ideas were a bit “over the top” for this elite group of “planters, merchants and professionals” assembled to form the beginnings of a nation. See Sean W. Lentz, *The Rise of American Democracy from Jefferson to Roosevelt* (New York, 2005.)

[67] According to Jefferson: “The pusillanimous Idea that we had friends in England worth keeping terms with, still haunted the minds of many. For this reason those passages which conveyed censures on the people of England were struck out, lest they should give them offense." Autobiography - by Thomas Jefferson, 1743 – 1790. Yale University, The Avalon Project.

[68] See: David McCullough, *John Adams*. (New York 2002,) made into an HBO mini-series in 2008.

principally derived from those of John Locke, Algernon Sidney, and other English theorists, most of whom were contemporaries. It has also been asserted that the argument offered was not without flaws in history and logic. Jefferson rests his theories of the right of the colonists to separate from England on the fundamental doctrines of natural rights and of government under social contract. What Locke had contended for as an individual, the Americans proclaimed as a body politic; moreover, they made good the argument by force of arms.[69] It remains a great historical landmark in that it contained the first formal assertion by a whole people of their right to a government of their own choice. [70]

For our purposes here, the Declaration is most important, a statement of morality based upon ethical principles. The phrase that rises above the rest in its moral eloquence is of course, "We hold these truths to be self-evident, that all men are created equal, that they are endowed by their Creator with certain unalienable Rights, that among these are Life, Liberty and the pursuit of Happiness."

Jefferson and Franklin's "self-evident truths" lead us back to the idea of the concept of absolute truth. They tell us that there are many truths but some truths are truths *ipso facto.* They speak for themselves, everybody knows or should know this.

All men are created equal – While this is an *ipso facto* truth, the Congress as a whole succumbed to the exigencies of sustaining the already-present system of

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[69] Declaration of Independence (2007). In Encyclopædia Britannica. Retrieved January 23, 2007, from Encycopædia Britannica Online: http://www.britannica.com/eb/article-9042263.
[70] United States National Archives.

agriculture relying on African slavery. It took another almost 90 years to begin to rectify this failure on their part.[71]

Endowed by their creator – an acknowledgement that these truths come from a source outside man himself.[72]

Certain unalienable rights –A "right" is an entitlement and here it is an entitlement that is *unalienable*, literally "cannot be made foreign."

Life, liberty and the pursuit of happiness – When the Declaration was first published internationally, by happenstance in Ireland, [73]the European press seized upon this phrase to deride the colonists. "What does the pursuit of happiness mean," they asked? [74] Actually, the phrase was a euphemism for "property." Original drafts also had the word, "property" but "the pursuit of happiness" was substituted.[75]

Later, we will see these principles expanded upon and restated in modern language, where the right to "life" morphs into the right to "human dignity." For example, the preamble to the Charter of the United Nations "articulates the international community's determination "to reaffirm faith in fundamental human rights, [and] in the dignity and worth of the human person." [76]The Charter, as a binding treaty, pledges member states to promote universal respect for, and observance of, human rights and

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[71] Slavery was "abolished" in 1862 by Abraham Lincoln's Emancipation Proclamation. The Proclamation added the de facto to the *de jure* statement of Jefferson/Franklin. However, it can be argued that the Proclamation itself though morally right was legally wrong in that it was an exercise of *ultra vires* power by the President. Nevertheless, history has borne out its wisdom.
[72] The writer herein takes this as one of the bases for my concept that one lives best when he lives "outside himself."
[73] *The Belfast Newsletter*, August 23, 1776.
[74] *The Gentleman's Magazine*, vol. 46, pp. 403-404.
[75] In his *The Second Treatise of Civil Government*. (London, 1690,) John Locke, to whom Jefferson was literarily indebted, had penned the words: " (A)ll men are naturally in...a state of perfect freedom to order their actions, and dispose of their possessions and persons, as they think fit, within the bounds of the law of nature, without asking leave, or depending upon the will of any other man."

fundamental freedoms for all without distinction as to race, sex, language, or religion (Arts. 55–56).[77]

Another modern restatement of Jefferson's principles is the principle of "autonomy" found in the Belmont Report, the statement of the rights of subjects of scientific experimentation brought about by the infamous *Tuskeegee Syphillis Experiment.*[78]

Not really related for our purposes but of interest is this. We all know that the Declaration of Independence has also been a source of inspiration outside the United States. It encouraged Antonio de Nariño and Francisco de Miranda to strive toward overthrowing the Spanish empire in South America, and it was quoted with enthusiasm by the Marquis de Mirabeau during the French Revolution. Of really acute historical irony is the fact that the Preamble to the Declaration was quoted almost ver batem by Ho Chi Minh in the writing of the 1945 Declaration of Independence of Vietnam.[79]

Lastly with the Declaration, we see the phrase, "[t]hat to secure these rights, Governments are instituted among Men . . ." In this, we find the moral foundation for the existence of government, to "secure these rights." Public Health is a creature of government. Securing these rights is part of our ethical duty as well.

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[76] Articles Fifty-Five and Fifty Six, the Charter of the United Nations.

[77] See cited in Lawrence O. Gostin , *Public Health Law and Ethics*, Chapter One, "Public Health Law, Ethics and Human Rights: Mapping the Issue," (University of California) at page 10.

[78] The *Belmont Report* was a report created by the former United States Department of Health, Education, and Welfare (which was renamed to Health and Human Services) entitled "Ethical Principles and GuIelines for the Protection of Human Subjects of Research." http://ohsr.od.nih.gov/guidelines /belmont.html. Two volume set, DEW Publication No. (OS) 78-0013 and No. (OS) 78-0014.

[79] Declaration of Independence. (2007). In *Encyclopædia Britannica.* Retrieved January 23, 2007, from Encyclopædia Britannica Online: http://www.britannica.com/eb/article-9042263.

These principles began to be displayed immediately in George Washington and others. Washington displayed remarkable ethical principle in his command of the troops of the Continental Army and especially in his treatment of prisoners. In his book, *Washington's Crossing*, [80] Fischer remarks on Washington's treatment of Hessian prisoners of war captured after a bloody battle in which the Hessians had brutalized the Continentals, "giving no quarter." After the Battle of Princeton, Washington put a trusted officer in charge of the 211 captured privates with these instructions:

> treat them with humanity, and Let them have no reason to Complain of our Copying the brutal example of the British army in their Treatment of our unfortunate brethren. ... Provide everything necessary for them on the road. Hessian prisoners were so well treated that, once they had got over the shock of it, they could be sent from one holding place to the next without an armed escort. After the war, almost a quarter of the Hessians remained in America. Their names still dot the phone book in Chester County, Pa.[81]

Likewise, even the pragmatic John Adams sought the ethical high ground in the Revolution. Adams wrote to his wife, Abigale on February 17, 1777

> Is there any Policy on this side of Hell, that is inconsistent with Humanity? I have no Idea of it. I know of no Policy, God is my Witness but this -- Piety, Humanity and Honesty are the best Policy. Blasphemy, Cruelty, and Villany have prevailed and may again. But they wont prevail against America, in this Contest, because I find the more of them are employed the less they succeed.[82]

In 1787, these principles emerge again in the Constitution.

The Constitution of the United States

> *We the People of the United States, in Order to form a more perfect Union, establish Justice, insure domestic Tranquility, provide for the common defence, promote the general Welfare, and secure the Blessings of Liberty to ourselves and our Posterity, do ordain and establish this Constitution for the United States of America.*

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[80] David Hackett Fischer, *Washington's Crossing* (New York, 2004)

[81] Id.

[82] Adams Family Papers, an electronic archive. http://www.masshist.org/DIGITALADAMS/AEA/

Justice Anthony Kennedy followed his comments concerning the Declaration of Independence [83] with a similar comment concerning the Constitution. Americans are such a people of law – "a government of laws not men," [84] that the founding fathers felt it incumbent upon themselves to write our national ethical principles in the foundational law of the nation – the Constitution.

The Constitution was written by several committees over the summer of 1787, but the committee most responsible for the final form we know today is the "Committee of Stile [*sic.*] and Arrangement." This Committee was tasked with getting all of the articles and clauses agreed to by the Convention and putting them into a logical order. On September 10, 1787, the Committee of Style set to work, and two days later, it presented the Convention with its final draft. The members were Alexander Hamilton, William Johnson, Rufus King, James Madison, and Gouverneur Morris. The actual text of the Preamble and of much of the rest of this final draft is usually attributed to Gouverneur Morris.[85]

We could say much about the Constitution, but for our purposes here, let's isolate on the ethical principles it espouses in the preamble quoted *supra*.

We the People of the United States – Certainly, the Framers were an elite group, many were educated and property owners, they were among the best and brightest America had to offer at the time. In stark contrast to the *Divine Right of* Kings, these men established their concept of government on the principle enunciated by Jefferson in the

[83] Note 42 at page 18, *q.v.*
[84] Attributed to John Adams, "Novanglus Papers," no. 7.—The Works of John Adams, ed. Charles Francis Adams, vol. 4, p. 106 (1851).

Declaration – that of the "social contract," government was with the consent of the governed. That, in and of itself, is a principle moving toward "personal autonomy."[86]

As theoretically enticing and noble as this sounds, it may well be stated that the over-riding reason they enunciated this principle of governance was more likely pure practicality. Why would the people of this Continent want to exchange the tyranny of one monarch for the possibility of tyranny by another or by an elite oligarchy. They all knew they were taking their lives into their own hands [87] and having taken this step, from a personal standpoint, they could not afford to fail. In other words living by this moral principle – personal choice and autonomy – was beneficial to the society they sought to establish, but also to themselves as individuals.

This is a lesson in the practicality of principle for us as public health professionals. We should seek to be ethical beings not only because of principle but also, because it works.

Establish Justice – "What is justice"? Classically, there are a variety of ways to look at it. Some would define "justice" in terms of equality--everyone should get or have the same amount, regardless of how hard they work, or "what they put in."

Other people define "justice" in terms of equity--people should get benefits in proportion to what they contributed to producing those benefits. Still other people believe in equity with a bottom "safety-net" level which protects people who, because of misfortune or disability, are unable to work or even help themselves. Still another

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[85] Richard Brookhiser, Gentleman Revolutionary: *Gouverneur Morris, the Rake Who Wrote the Constitution*. New York, 2003.

[86] See the Belmont Report, *infra.*

[87] Franklin is quoted as saying, "we must all hang together or we will surely hang separately." Albert Henry Smyth, ed. *The Writings of Benjamin Franklin*. (1907)

definition of justice focuses not on output, but on process. Results can be "just" if they were obtained by a "just" or fair process. [88] Whichever definition we choose, it is going to involve some measure of fairness.

Insure Domestic Tranquility – *Peace.* The framers realized that only government can keep the peace. If there is not peace within a society, the society breaks down. One of the events that caused the Convention to be held was the revolt of Massachusetts farmers knows as Shays' Rebellion. Prior to Shays' Rebellion, it might have been thought that the United States could continue under the Articles of Confederation. However, the idea that there was not peace at home, was perhaps the last straw in helping the framers of the Constitution realize that there had to be a mechanism to preserve the peace at home or the society would fall on itself. [89]The taking up of arms by war veterans revolting against the state government was a shock to the system that had greater ramification than anyone thought.

Promote the General Welfare - This, and the next part of the Preamble, are the culmination of everything that came before it - the whole point of having tranquility, justice, and defense was to promote the general welfare - to allow every state and every citizen of those states to benefit from what the government could provide. [90]

V. Professional Ethics that Bear Upon Public Health

- The Hippocratic Oath and Medical Ethics including Augustine's "Just War"
- Pharmacists' Ethics
- Nursing Ethics
- The Belmont Report and Institutional Review Boards
- The Public Health Code of Ethics
- Public Officer and Employee Ethics Laws

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[88] Conflict Research Consortium, University of Colorado, Boulder. CO.

[89] See: *Shays' Rebellion: The American Revolution's Final Battle* (U. of Pennsylvania Press, 2002).

[90] United States National Archives.

Is it ethically OK to kill people?
Is it Ok to let them die?

An Introduction to Dying

Our profession shares in common with medicine and nursing [91] the idea that we exist to help keep people alive, *primum non nocere*, first do no harm. [92] Is the prevention of death or at least the refraining from affirmatively causing death *always* the ethical goal of man? The writer here attended military school during the Vietnam era. In anticipation of our potential military service and the likelihood, given the historical period in which we lived, of seeing combat, we had drilled into us on a daily basis the mission of the military combat squad, "to *kill*, capture or destroy the enemy by fire and maneuver." [93]To kill – we - and soldiers - were and would be trained to *kill.* To paraphrase the aforementioned "Golden Rule," [94] we trained not to "do unto others as we would have them do unto us," but to "do unto others, then *cut out*." Is that ethically a bad thing? We will not spend too much ink on this point, but since later we will discuss public health professionals if not *killing* people, at least volitionally allowing them to die in a disaster scenario, a word or two on the ethics of killing is called for.

One would assume that in pre-recorded history somewhere, some *homo sapien sapien* picked up and rock a killed another *homo sapien*. Was it justified?

In recorded history we have the first murder found in the Judeo-Christian teaching when Adam's son, Cain murdered his brother, Abel because God had accepted Abel's

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[91] *Q.v. infra.*
[92] See the section on The Hippocratic Oath and Medical Ethics, *infra.*
[93] US Army Field Manual FM 7-8, "Infantry Rifle Platoon and Squad," April, 1992.

sacrifice and not Cain's.[95] God clearly condemns this action. [96] Further, in his Commandments to Moses, [97] God forbids what the King James Version calls "killing." Many modern translations read this as "committing murder."[98]

So, is God against all volitional killing? Apparently not since there are numerous examples of God instructing the Israelite nation on their sojourn to take the Land of Canaan, not only to kill the soldiers of the native peoples, but the women, children and animals as well.[99] Likewise in Numbers Chapter 35, God sets up cities of refuge to which the one who has killed another may run for protection from the "avenger of blood."

We see here at least two principles justifying volitional killing. First the "avenger of blood," himself is allowed to kill another if the other has been found guilty of murder. Fulfilling the theory of *lex talionis,* [100]the Avenger of Blood is the state-authorized executioner. Moses was not the first to employ the *lex talionis*, it was well established in the neighborhood already extant for centuries.[101] Moses records another point about justifiable killing in the passage cited *supra.*, accidental killing. [102]

In our Common-law based legal system, we recognize a number of justifications for the taking of human life. Following up on Moses, many jurisdictions still authorize

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94 *Q.v., supra.*
95 Genesis 4:8-15.
96 Genesis 4:23.
97 *Q.v. supra.*
98 See: Exodus 20:14 and Deuteronomy 5:17.
99 Deuteronomy 20:10-17.
100 *Lex talionis* was the early theory of order that allowed equal repayment for the transgression to be made by the victim or a member of the victim's family. The name comes from the phrase, "eye for eye and tooth for tooth." *Taliois* is Latin for "tooth," thus the "law of the tooth" or *lex talionis*.
101 The Code of Hammurabi (also known as the *Codex Hammurabi* and *Hammurabi's Code*), created ca. 1760 BC, mentions the principle.
102 Numbers 35:15.

state executions under appropriate circumstances. While state-sanctioned execution is certainly a subject for hot ethical debate, in many states, it is still the law and the United States Supreme Court in a somewhat divided opinion, has recently ruled that the practice, *per se* is not violative of the Constitution if carried out in a proper manner. This was the first time in over 100 years a substantive Eighth Amendment challenge to a particular *method* of execution reached the High Court. In January, 2008, the Supreme Court held in Baze v. Rees, [103] that The Kentucky Supreme Court rightly held that the Kentucky state lethal injection protocol does not violate the Eighth Amendment because it does not create a substantial risk of wanton and unnecessary infliction of pain, torture, or lingering death. Baze was a case brought by two Kentucky death row inmates who argue that Kentucky's three-drug lethal injection protocol violates the Eighth Amendment ban on "cruel and unusual" punishment. The death row inmates in Baze argue that Kentucky's methods and procedures for carrying out execution by lethal injection is likely to lead to excruciating pain prior to death and is, therefore, a cruel and unusual form of punishment forbidden by the Eighth Amendment to the U.S. Constitution.[104] The Court now rules the practice to be constitutional. [105]

The law also recognizes killing due to self defense and defense of another under certain circumstances when there is a reasonable belief that the life of the actor or third party is threatened by the perpetrator and that killing the perpetrator is the reasonable course of action.[106]

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[103] See Baze v. Rees, --- S.Ct. ----, 2007 WL 2075334 (U.S. Ky. Sep 25, 2007) (NO. 07-5439.)

[104] Nathan, Alison, *Jurist Legal News and Research*, University of Pittsburg School of Law, retrieved October 2, 2007.

[105] Baze v. Rees, 128 S.Ct. 1520 (2008.)

[106] See *Code of Ala. 1975*, §13A-3-23 and 73 ALR4th 993.

But back to the Army, is killing by soldiers morally and ethically permissible? While some would argue that no killing is ethical,[107] even one of the great saints of the Church authorized killing under terms of what he called "just war." St. Augustine of Hippo (3rd century AD) wrote in *Summa Theologica* [108] that a war and the killing of soldiers that ensues is ethically permissible when the war is waged by a lawful authority, it is defensive in nature, waged with the right reasons, is authorized by legitimate government and is proportional to the underlying precipatory cause.

The *Summa Theologica* gives the rule for conduct of war (*jus ad bellum*) while international rules of warfare such as the Geneva Convention [109] give the rules for the conduct *in* war (*jus in bellum*.) I would refer you back to Washington's treatment of the Hessians, *q.v.* The point is that in some circumstances, traditional wisdom has it that war and the killing that ensues is ethically permitted.

The Hippocratic Oath and Medical Ethics

> *I swear by Æsculapius, Hygeia, and Panacea, and I take to witness all the gods, all the goddesses, to keep according to my ability and my judgment, the following Oath. To consider dear to me as my parents him who taught me this art; to live in common with him and if necessary to share my goods with him; To look upon his children as my own brothers, to teach them this art if they so desire without fee or written promise; to impart to my sons and the sons of the master who taught me and the disciples who have enrolled themselves and have agreed to the rules of the profession, but to these alone the precepts and the instruction. I will prescribe regimens for the good of my patients according to my ability and my judgment and never do harm to anyone. To please no one will I prescribe a deadly drug nor give advice, which may cause his death. Nor will I give a woman a pessary to procure abortion. But I will preserve the purity of my life and my arts. I will not cut for stone,*

[107] See the Hindu principle discussion, *supra*.

[108] See: *Augustine: Political Writings*, Michael W. Tkacz and Douglas Kries, trans, Ernest L. Fortin and Douglas Kries, eds., 1994.

[109] Actually, there are four Conventions of Geneva and three separate protocols, all most recently updated in 1949 under the collective rubric of "The Geneva Conventions of 1949." There are approximately 200 signatory nations.

*even for patients in whom the disease is manifest; I will leave this operation to be performed by practitioners, specialists in this art. In every house where I come I will enter only for the good of my patients, keeping myself far from all intentional ill-doing and all seduction and especially from the pleasures of love with women or with men, be they free or slaves. All that may come to my knowledge in the exercise of my profession or in daily commerce with men, which ought not to be spread abroad, I will keep secret and will never reveal. If I keep this oath faithfully, may I enjoy my life and practice my art, respected by all men and in all times; but if I swerve from it or violate it, may the reverse be my lo*t.[110]

We could write a lot on the Oath of medicine, but for these purposes, it is more important to see the contrasts with generally accepted principles practiced in the realm of public health.

Who has not heard of the Hippocratic Oath, traditionally taken by physicians as a rite of passage into the profession? It is attributed to its namesake, Hippocrates, the father of medicine, *circa.* 4th Century B.C. It is postulated that it could have been written by one of his students. First thoughts of the Oath would instinctively lead us to the concept of "first, do no harm," *primum non nocere*. It is a common misconception that the phrase *primum non nocere*, "first, do no harm" is included in the Hippocratic Oath. It is not, but seems to have been derived through Galen from Hippocrates's Epidemics in which he wrote, "Declare the past, diagnose the present, foretell the future; practice these acts. As to diseases, make a habit of two things-to help, or at least to do no harm." What it, or more precisely the modern versions of it do teach are the following principles.

- Always look to the good of the patient and harm no one – the patient's interest comes first. This immediately puts the practice of medicine sometimes at odds

[110] The Hippocratic Oath Original, translated from the Greek.

with the practice of public health which would put the interest of society ahead of that of an individual.[111]

- Place a high value on human life. The original included a prohibition against inducing abortion. Some modern versions delete that reference.
- Perform only within one's area of expertise and training. This also could conceivably cause an ethical conflict for physicians assisting in disaster settings when the conditions cannot be controlled and everyone must pitch in and do what must be done.
- Refrain from any sort of sexual conduct with patients. This is a statement about the use of the position of authority for personal gratification.[112] One would hope that such a statement would go without saying – history dictates that it does not. This principle serves as the basis for a prohibition against any sort of conflict of interest.
- Maintain patients' information and secrets inviolate. This, again is another pointed difference with the concepts of public health but rests in essence on the fact that medicine values the patient's interest above all while public health must, by definition, take a more societal view.

[111] Lawrence O. Gostin says, "Most definitions [of public health] share the premise that the subject of public health is the health of populations—rather than the health of individuals—and that this goal is reached by a generally high level of health throughout society, rather than the best possible health for a few. The field of public health is concerned with health promotion and disease prevention throughout society. Consequently, public health is less interested in clinical interactions between health care professionals and patients, and more interested in devising broad strategies to prevent, or ameliorate, injury, and disease. *Gostin, supra.*

[112] This will reappear in the section on public officers and employees' ethics laws.

- Do not violate the laws or morals of the community. Modern views of this tend toward the idea of losing a medical license for having committed a "crime of moral turpitude."

Robert Orr summarizes medical ethics into four principles: non-maleficence, doing no harm; beneficence, doing what is best for the patient; autonomy, allowing the patient the informed right to choose; and justice, treating everyone alike. [113] These are the ethical principles that have guided medicine for thousands of years. But, what about in a disaster? Well, interestingly enough, according to historians, the history of physicians' responses to contagions is mixed.

> Galen is reported to have fled from Rome during a plague in 166. Although in the 14th century some physicians stayed and cared for the sick, most responded to the Black Death by fleeing. Defoe indicates in *A Journal of the Plague Years*, a novelistic chronicle about London's great plague of 1665, that most physicians were called "deserters". [114]

In the mid-19th century, nascent professional organizations began to articulate the physician's ethical obligation to care for the sick during epidemics.

The World Health Organization observes that in the past, the American Medical Association (AMA) code of ethics had "quite explicit" guidance for physicians in particular regarding their duties and obligations during an infectious disease outbreak. For example, for over 100 years the following provision was found in the AMA code of ethics: "when pestilence prevails, it is their (physicians') duty to face the danger, and to continue their labours for the alleviation of suffering, even at the jeopardy of their own

[113] Robert D. Orr, Director of Ethics, Fletcher Allen Health Care. "Ethical Issues in Bioterrorism," prepared in association with the University of Vermont College of Medicine (2003.)

[114] Emmanuel, Ezekiel, MD., Ph.D. "The Lessons of SARS," Annals of Internal Medicine, Vol 39, issue 7, October 7, 2003.

lives. (Huber and Wynia 2004.)" [115] Interestingly enough, this particular provision was deleted from the AMA code of ethics over fifty years ago. "It is questionable," they state, "whether such stringent requirements would be endorsed as an expectation by current professional associations."[116] Currently, the AMA addresses the issue of the conflict between medical ethics and the ethics of a disaster:

> National, regional and local responses to epidemics, terrorist attacks and disasters require the involvement of physicians. Because of the commitment to care for the sick and injured, individuals have an obligation to provide urgent medical care during disasters. This ethical obligation holds true in the face of greater than usual risks to their own safety, health or life. The physician workforce, however is not an unlimited resource; therefore, when participating is disaster responses, physicians should balance the benefits to individual patients with the ability to care for patients in the future.[117]

A take away from this policy statement is first and foremost, that physicians have an *affirmative duty* to participate in disaster preparedness *and response*. The quoted statement goes on to urge physician participation in the planning and conceptualizing for such response in advance.

Further, physicians have *an affirmative duty* to actually provide urgent care in a disaster. What if such care is outside their area of expertise? Does this mean merely that physicians who are presented with disasters must perform in the midst of the disaster or does it mean that if they are not on duty the night the dam breaks, they have a duty to voluntarily report to the hospital to lend support to their brothers and sisters? When can the physician quit and go home if people are still sick and dying? That remains to be

[115] "The Role and Obligations Of Health-Care Workers During An Outbreak Of Pandemic Influenza," World Health Organization Working Paper, Dr Ross Upshur, University of Toronto, Chairman. September 14, 2006.
[116] Id.

seen. E-9.067 instructs the physician to "balance the interests" of staying tonight to perform and getting some rest so he or she can live to fight another day.

In June 2001, the AMA issued a revised and expanded version of the Principles of Medical Ethics (last published in 1980). That document further discusses the longstanding tension between physician's autonomy rights and societal obligations in the AMA Code. Dr. CC Clark, Department of Philosophy and the Institution for Social and Policy Studies, Yale University, argues that a duty to treat overrides AMA autonomy rights in social emergencies, even in cases that involve personal risk to physicians such as would be posed by bioterrorist attack or other catastrophic causes.[118]

The University of Toronto Joint Centre for Bioethics, prepared a report on the ethical concerns presented in planning for the pandemic influenza.[119] This will be discussed more fully *infra.* However the point of physician's ethical duty to "stay and fight," *vel non*, is summarized at page 8. The working group concludes:

The duty to care for the sick is a primary obligation for health care workers for a number of reasons, including:

- the ability of physicians and health care workers to provide care is greater than that of the public, thus increasing their obligation to provide care.
- by freely choosing a profession devoted to care for the ill, they assume risks.
- the profession has a social contract that calls on members to be available in times of emergency.[120]

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[117] AMA Policy Statement E-9.067, *Physician Obligation in Disaster Preparedness and Response.* December, 2004, based on the report "Physician Obligation in Disaster Preparedness and Response, adopted June, 2004.

[118] Chalmers C. Clark, *In Harm's Way: AMA physicians and the duty to treat.* The Journal of Medicine and Philosophy, Volume 30, Number 1, April 2005, pp. 65-87(23).

[119] "Stand Guard for Thee – Ethical Considerations in Preparedness planning for Pandemic Influenza," A Report of the University of Toronto Joint Centre for Bioethics, Pandemic Influenza Working Group.

The report goes on to compare physicians and other health care workers to fire fighters who "do not have the freedom to choose whether or not they have to face a particularly bad fire. . . ;" and to police officers who "do not get to select which dark alleys they walk down."[121] The issue, however, is not settled – it should be before the time to act comes.[122]

Nurse's Ethics [123]

Likewise, such ethical concerns still linger in the nursing profession. The American Nursing Association (ANA) issued a paper entitled "Ethics and Human Rights Position Statements: Risk Versus Responsibility in Providing Nursing Care." [124] In this statement, the ANA believes that nurses are obligated to care for patients in a "non-discriminatory" manner yet, they say, the Association "recognizes that there may be limits to the personal risk of harm the nurse can be expected to accept as an ethical duty." The summary of the ethics of the profession on this point goes on to hold that the nurse is not at liberty to abandon those in need of nursing care or at least to assure that alternate care is available unless there are conditions peculiar to this nurse that would limit the nurse's ability to

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[120] In addition, they largely work in publicly supported systems in many countries, remember these are Canadians writing this report.

[121] Id.

[122] One of my ethical principles espoused herein is the Idea that decisions makers or as President Bush has said, "the decider," should make assume a role of moral leadership and advance to making these difficult decisions "in the sunshine."

[123] Nursing has a long history of human rights. Nurse Clara Barton was one of the chief proponents of the United States becoming a signatory to the First Geneva Convention in 1892, *q.v., supra.*

[124] American Nurses Association (1994), "Risk Versus Responsibility in Providing Nursing Care", available online at HTTP://www.nursingworld.org. Effective December 8, 1994. Cited as authoritative by Professor James Tabery, University of Pittsburg. See attached reading list.

perform or place the nurse at peculiar harm not characteristic of any other nurse in the same circumstance.[125]

Interpreting the statement as a lawyer would, I suggest it means that a nurse is excused from duty if she has a personal circumstance peculiar to the nurse that would not be common to other nurses similarly situated. That is to say, if this nurse is immuno-compromised, that may be an excuse to go home. However, because there is a risk in a pandemic of infection or even death and the nurse has responsibilities at home, such is not an excuse because any other nurse would be exposed to the same risk of infection and death and most of us have other responsibilities away from the work-place.

One could hearken back to the general statement by the Toronto group applicable not only to physicians, but to *all* health-care providers that in choosing this field, the person has chosen to forfeit some personal freedoms of choice in favor of the assumption of a public duty. Again in lawyer terms, the nurse had no duty to perform when the nurse signed up to be a nurse, that was done voluntarily; however, in signing up the nurse has assumed the risk and now is under a duty to perform. The ANA closes this position thusly: "Nursing is a caring profession . . . because of nursing's long history of standing ready to assist the sick and vulnerable in society, society has come to rely on nursing and to expect that it will rise to the health demands of virtually any occasion." Yet, there may be limits. Nursing gives us four criteria to help judge when the moral duty to perform falls inextricably upon the nurse.

- The client is in significant risk of harm . . . if the nurse does not assist.
- The nurse's intervention is directly relevant to prevent harm.

[125] This ethical standard is informed by the controversies in the 1990s brought about by hepatitis- B or C, TB and HIV/AIDS and the possibility that the particular nurse my be unusually susceptible because of some immuno-compromised situation extant in the nurse. See T. Brenner, *Occupational Transmission of HIV: AN Ethical and Legal Challenge* (Binghamton, New York, 1990)

- The nurse's care will probably prevent harm. . .
- The benefit the client will gain outweighs any harm the nurse might incur and does not present more than an acceptable risk to the nurse.[126]

The Ethics of the Pharmacist

As all pharmacists reading this will remember from their history, pharmacy is as ancient as medicine and co-developed with that art. In the far distant past, somebody expressed juice from leaf and applied it to a wound – in so doing became the first pharmacist. Like medicine, the art goes back into the Greek legends and Egyptian science. Legendarily, Asclepius, the god of the healing art, by whom all new physicians swear in the Hippocratic Oath [127] delegated to Hygieia the duty of compounding his remedies. She was his apothecary[128] or pharmacist. Egyptian science divided "physicians" into those who visited the sick and those who remained in the temple and prepared remedies for the patients. This separation was carried on by the Greeks and Romans and on into the new millennium by the Arabs. Finally, the separation became the law.[129]

Growing from the same root, the twin trees of medicine and pharmacy share many ethical principles in common. The Alabama Board of Pharmacy maintains a Code of Professional Conduct which requires *in para materia*, at *Alabama Administrative Code,* R. 680-X- 2-.22:

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[126] See ANA position paper cited *supra.*

[127] See note 107.

[128] From the Greek, *apothēkē,* one who "puts away."

[129] Pharmacy. (2008). In *Encyclopædia Britannica.* Retrieved May 7, 2008, from Encyclopædia Britannica Online: http://www.britannica.com/eb/article-9110321. See also the Statute of Bruges, 1683, which forbade physicians to prepare medicines for their patients. See also: *Code of Ala. 1975*, § 34-23-1, *et seq.*

> (a) A pharmacist should hold the health and safety of patients to be of first consideration and should render to each patient the full measure of professional ability as an essential health practitioner[130]

An interesting comparison is drawn from a synoptic look at the Hippocratic Oath [131] and the 1994 Code of Ethics of the American Pharmacists Association (APhA.) [132] Many pharmacists' principles go back to Hippocrates. These are the ethical principles of the pharmacist on a "sunny day" – but what about on those "rainy days and Mondays" that always "get us down."[133] I suggest one should isolate on Principles Numbers VII and VIII which state in paraphrase that though the pharmacist has a duty to put his patient first, he or she also has a duty to society as a whole and must balance those duties in the shortage caused by the disaster in a "fair and equitable manner."

In a letter to HHS concerning the planned distribution of the pandemic influenza vaccine, [134]APhA Executive Vice-President and CEO, John A. Gans, PharmD, details how pharmacists are on the front lines on any disaster and how they would be all the more so on the front lines of pandemic. His goal is to persuade HHS into raising the vaccine priority for pharmacists and associates during the pandemic or pre-pandemic phase. He states: "[p]harmacists are prepared to serve as frontline providers of medication and vaccination clinical services as part of the healthcare team that would be mobilized in response to such a pandemic outbreak." He states that pharmacists are prepared to be motivators, hosts and vaccinators. They would be on the front lines of

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[130] For full text, see **Attachment 4,** *supra.*
[131] See note 107.
[132] *Code of Ethics*, American Pharmacists Association , adopted by the membership of the American Pharmacists Association October 27, 1994. Full text at **Attachment 5,** *supra.*
[133] "Rainy Days and Mondays", by Roger Nichols and Paul Williams as performed by the *Carpenters*.
[134] "APhA Response to HHS Draft Influenze Prioritization, December 31, 2007 U.S. Department of Health and Human Services Room 434E, 200 Independence Avenue, SW Washington, DC 20201 Attention: Pandemic Influenza Vaccine Prioritization Guidance Comments

educating members of the public in what they should do to protect themselves and in motivating the public to "follow the plan." Pharmacists would be able to house drugs [obviously] and to host in their parking lots large gathering of members of the public to receive vaccinations and in providing those vaccinations themselves.

Our Alabama experience is that large numbers of pharmacists have become Public Health volunteers to assist with POD sites where vaccine would be dispensed should the "push-pack" be called for.

In a document named "A Pharmacist's Guide to Pandemic Preparedness", prepared jointly by the APhA, American Society of Health-System Pharmacists, and National Association of Chain Drug Stores Foundation, [135] with regard to preparedness and especially with regard to pandemic preparedness, pharmacists are urged to:

- Complete basic life support skills (CPR) and keep certification up to date.
- Participate in emergency planning meetings and exercises with local and state health departments.
- Participate in your health-system, local/ state public health, and emergency management response educational and training initiatives (for example, Medical Reserve Corps)
- Understand the basic tenets of the National Incident Management System and the Hospital Emergency Incident Command System.
- Get trained to administer immunizations through APhA's nationally recognized immunization certificate training program. [and]

[135] See: "A Pharmacist's Guide to Pandemic Preparedness", July 2007, Issued by APhA, ASHP, and NACDS Foundation. - Pedersen C, et al, "Pharmacists' Opinions Regarding Level of Involvement in Emergency Preparedness and Response", J Am Pharm Assoc. 2003;43:694–701.

- Complete an annual education program on influenza and other potential public health issues. . .

Pharmacists are also advised to be involved in the planning process for the distribution of anti-virals and the maintenance of the flow medications in a pandemic. Perhaps more than the other professional associations, pharmacists are urged to "step up to the plate" on pandemic related issues in furtherance of their public service obligations.

The Code of Ethics of the EMT[136]

Emergency Medicine came a little late in the game to the health care health care profession.

Few people realize that modern emergency medical service has only been around for the past 70 years. This is the timeline of EMS from the very beginning when mankind started to provide pre-hospital care and its progression through the years.

1865 - America's first ambulance service is instituted by the U.S. Army.

1869 - America's first city ambulance service (utilizing horse drawn carriages) is instituted in NewYork City by Bellevue Hospital.

1870 - Prussian siege of Paris used hot air balloons to transported wounded soldiers. This was the first documented case of aeromedical transportation.

1899 - Michael Reese Hospital in Chicago began to operate an automobile ambulance which was capable of speeds up to 16 mph.

136 Information on the progression of EMS was obtained from the following sources: Emergency Medical Services - 2nd Edition (1978) by James O. Page Making a Difference - The History of Modern EMS (1997) by James O. Page The Paramedics (1979) by James O. Page. 15 Years of Paramedic Engines (1993) by Gary Morris. Osage Ambulance District http://www.osageamb.com/history_of_ems.htm accessed January 21, 2009.

1910 - First known air ambulance aircraft was built in North Carolina and tested in Florida. The aircraft failed after flying only 400 yards and crashing.

1926 - Phoenix Fire Department begins "inhalator" calls.

1928 - Julien Stanley Wise implemented the first rescue squad (Roanoke Life Saving Crew) in the nation in Roanoke, VA.

1940's - Prior to World War II, hospitals provided ambulance service in many large cities. With the severe manpower shortages imposed by the war effort, it became difficult for many hospitals to maintain their ambulance operations. City governments in many cases turned ambulance service over to the police or fire department. No laws required minimal training for ambulance personnel and no training programs existed beyond basic first aid existed. In many fire departments, assignment to ambulance duty became an unofficial form of punishment.

1951 - Helicopters began to be used for medical evacuations during the Korea war.

1956 - Dr. Elan & Dr. Safar developed mouth-to-mouth resuscitation.

1959 - Researchers at John's Hopkins Hospital in Baltimore, MD developed the first portable defibrillator as well as perfected CPR.

1960 - Martin McMahon experimented with various types of artificial respiration by paralyzing Baltimore City firefighters and seeing which method worked best. Los Angeles County Fire Chief Keith Klinger proudly announced that every engine, ladder and rescue company in his department was equipped with a resuscitator. His department is believed to have been the first large department to adopt uniformly medical emergency responsibility.

1965 - More people died this year in auto accidents (50,000) than in 8 years of the Vietnam War. President L. Johnson signed into law the National Highway Safety Act which started the National Highway Traffic Safety Administration.

1966 - The National Research Council publishes a research paper, "Accidental Death & Disability - The Neglected Disease of Modern Society". Otherwise known as "The White Paper", this work was the catalyst for improving the delivery of pre-hospital care to this day. An excerpt from the report states: "Expert consultants returning from both Korea and Vietnam have publicly asserted that, if seriously wounded, their chances for survival would be better in the zone of combat than on the average city street."

1966 - Dr. Pantridge in Belfast, Ireland, started to deliver pre-hospital coronary care using ambulances. His research showed that his program significantly improved patient survivability in out-of-hospital cardiac events. In Pittsburgh, citizens demand an ambulance service to transport minority citizens. Freedom House Enterprises took 44 unemployed 18-60 year old men and gave then 3,000 hours of medical training. The program was deemed a success.

1967 - The American Ambulance Association publishes an article that states that as many as 25,000 Americans are either crippled or left permanently disabled as a result of the efforts of untrained or poorly trained ambulance personnel.

1968 - St. Vincent's Hospital in New York City started this nation's first mobile coronary care unit. The program at first used physicians, then paramedics. The American Telephone and Telegraph starts to reserve the digits 9-1-1 for emergency use. In Virginia,The Virginia Ambulance Law is passed and establishes the state's authority to regulate ambulances, verify first aid training, and issues permits.

1969 - The Miami,FL Fire Department started the nation's first paramedic program under Dr. Eugene Nagel. The very first out-of-hospital defibrillation occurred shortly thereafter (the patient survived and left the hospital neurologically intact). In Seattle, Dr. Leonard Cobb at Harbor View Medical Center teams up with the Seattle Fire Department and creates Medic I. Medic I is a Winnebago, (called "Mobi Pig" by the firefighters manning it), based at the hospital and is dispatched only on cardiac related calls.

1970 - The Charlottesville-Albemarle Rescue Squad in Charlottesville, VA starts the nation's first volunteer paramedic program under Dr. Richard Crampton. One of their first patients was President Lyndon Johnson, who suffered a heart attack while visiting his son-in-law Chuck Robb at UVA.

1971 - The television show Emergency! debuted. Emergency contributed to changed public attitudes concerning the fire service and emergency medical care. At the start of the show, there were only 12 medic units in the entire country. Four years later at least 50% of the population of this country was within 10 minutes of a medic unit.

1972 - The Department of Transportation and Department of Defense team up to form a helicopter evacuation service. In Seattle, Medic II is instituted. Medic II is a program to train 100,000 citizens in CPR. Harbor View Medical Center starts up the nation's most intensive training program for paramedics. The course is 5,000 hours long, compared to 3,600 hours a medical student endures to become a doctor!

1973 - St. Anthony's Hospital in Denver starts the nation's first civilian aeromedical transport service. (The program was called "Flight for Life"). The Star of

Life is published by the DOT. The EMS Systems Act (public law 93-144) is passed by Congress, which funds 300 regional EMS systems.

1974 - A Federal report discloses that less than half of the nation's ambulance personnel had completed the Department of Transportation 81-hour basic training course or its equivalent.

1975 - The American Medical Association recognizes emergency medicine as a specialty. The University of Pittsburgh & Nancy Caroline MD, is awarded a contract to develop the first nationwide paramedic training course. The National Association of EMT's is formed.

1977 - The National Council of EMS Educators is formed.

1978 - Phoenix Fire Department implements paramedic engine companies.

1979 - The Journal of Emergency Medical Services (JEMS) starts publication. The American Ambulance Association is formed.

1980 - The National Registry of EMT's published its first national standard exam for EMT-Intermediate.

1981 - Direct funding of EMS systems by the Federal Government is replaced by block grants. A study shows that 73 percent of all American fire departments, career and volunteer, are involved in some level of EMS service. In Salt Lake City, Jeff Lawson, MD, comes out with an emergency medical dispatcher program and priority dispatching. Nationwide, the medical community first recognizes AIDS.

1983 - Jack Stout starts systems status management in Denver. "One for Life" law is passed in Virginia. This law assesses one dollar from each motor vehicle license and

replaces all other state funding for emergency medical services. This provides funds to each city and county in Virginia and substantially increases support for regional EMS Councils, Rescue Squad Assistance Fund and EMT instructors.

1985 - The National Association of EMS Physicians is formed.

1986 - The Comprehensive Omnibus Budget Reconciliation Act (COBRA) is passed by Congress. This affected transfers of patients from ED to ED and prevented "dumping" (financially motivated transfers of patients).

1987 - Automatic Vehicle Locators (AVL) debuts.

1990 - The Trauma Care System Planning & Development Act is passed by Congress. Fire Department organizations join together in a resolution to expand into EMS.

1991 - The Commission on Accreditation of Ambulance Services sets standards and benchmarks for ambulances services to obtain.

1992 - American Medical Response starts to sell stock on the NYSE and starts a nationwide consolidation of the private ambulance industry. A public opinion survey conducted for the American College of Emergency Physicians found that nearly half of adult Americans could not identify 9-1-1 as the emergency number, or confused it with 4-1-1, the directory assistance number.

1993 - It is proposed that EMT-P's assume an expanded role in primary care of non-emergent patients by learning expanded skills.

1995 - Los Angeles City Fire Department institutes EMT Assessment & Paramedic Engine companies.

1996 - New York City EMS is absorbed by FDNY.

1997 - San Francisco and Chicago institute paramedic engine companies.

The National Association of Emergency Medical Technicians published its Code of Ethics which was adopted in 1978. It states:

> Professional status as an Emergency Medical Technician and Emergency Medical Technician-Paramedic is maintained and enriched by the willingness of the individual practitioner to accept and fulfill obligations to society, other medical professionals, and the profession of Emergency Medical Technician. As an Emergency Medical Technician-Paramedic, I solemnly pledge myself to the following code of professional ethics:
>
> A fundamental responsibility of the Emergency Medical Technician is to conserve life, to alleviate suffering, to promote health, to do no harm, and to encourage the quality and equal availability of emergency medical care.
>
> The Emergency Medical Technician provides services based on human need, with respect for human dignity, unrestricted by consideration of nationality, race creed, color, or status.
>
> The Emergency Medical Technician does not use professional knowledge and skills in any enterprise detrimental to the public well being.
>
> The Emergency Medical Technician respects and holds in confidence all information of a confidential nature obtained in the course of professional work unless required by law to divulge such information.
>
> The Emergency Medical Technician, as a citizen, understands and upholds the law and performs the duties of citizenship; as a professional, the Emergency Medical Technician has the never-ending responsibility to work with concerned citizens and other health care professionals in promoting a high standard of emergency medical care to all people.
>
> The Emergency Medical Technician shall maintain professional competence and demonstrate concern for the competence of other members of the Emergency Medical Services health care team.
>
> An Emergency Medical Technician assumes responsibility in defining and upholding standards of professional practice and education.
>
> The Emergency Medical Technician assumes responsibility for individual professional actions and judgment, both in dependent and independent emergency functions, and knows and upholds the laws which affect the practice of the Emergency Medical Technician.

An Emergency Medical Technician has the responsibility to be aware of and participate in matters of legislation affecting the Emergency Medical Service System.

The Emergency Medical Technician, or groups of Emergency Medical Technicians, who advertise professional service, do so in conformity with the dignity of the profession.

The Emergency Medical Technician has an obligation to protect the public by not delegating to a person less qualified, any service which requires the professional competence of an Emergency Medical Technician

The Emergency Medical Technician will work harmoniously with and sustain confidence in Emergency Medical Technician associates, the nurses, the physicians, and other members of the Emergency Medical Services health care team.

The Emergency Medical Technician refuses to participate in unethical procedures, and assumes the responsibility to expose incompetence or unethical conduct of others to the appropriate authority in a proper and professional manner.[137]

[137] National Association of Emergency Medical Technicians. http://www.naemt.org/about_us/emtoath.aspx

Tuskegee by the numbers:

- **600 men in the study**
- **399 - syphilis untreated 100 dead**
  - **74 men survived**
  - **40 wives with syphilis**
  - **19 children with syphilis**
  - **9,000,000 dollars paid**
  - **1 good result**

– The Belmont Commission

The Belmont Report and the Ethics of Institutional Review Boards

There have been many uplifting and morally upright chapters written in the history of the State of Alabama. However, one of them was *not* the infamous *Tuskegee Syphilis Experiment* that took place in the East Alabama town of Tuskegee with the full knowledge of the government of the United States and at least the acquiescence of the State of Alabama.[138]

As you will remember from your history, [139] beginning in 1932 and continuing until 1972, a group of 600 black men, 399 of whom were identified as being infected with syphilis and 201 without, rather than being treated, were instead surreptitiously monitored to see what the long term consequences would be.[140] In the 1970s, the truth, as it always does, began to out [141] and the consequences of this *very bad idea* were many and far-reaching. By the end of the study, only 74 of the test subjects were still alive.

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[138] The writer of this paper came to work in 1974 as neophyte young lawyer with the Alabama Department of Public Health in the waning days of the aftermath of the *Experiment* and was in on negotiations with chief counsel Fred Gray and other attorneys for plaintiffs in the litigations that ensued. Suffice it to say that it had been a dark 40 years.

[139] See *Tuskegee Timeline*, CDC. http://www.cdc.gov/nchstp/od/tuskegee/time.htm

[140] As the story goes, the men met weekly with Nurse Eunice Rivers, fictionalized in the play, "Miss Evers' Boys," their nurse, for what they thought was social gathering. In fact, they were tested and monitored to check on the progress of their syphilis.

[141] In 1966, Peter Buxtun, a PHS venereal disease investigator in San Francisco, sent a letter to the director of the Division of Venereal Diseases to express his concerns about the morality of the experiment. The Center for Disease Control (CDC) reaffirmed the need to continue the study until completion (until all subjects had died and had been autopsied). With his concerns rebuked, Buxtun went to the press. The story broke first in the Washington Star on July 25, 1972, then became front page news in the New York Times the following day. See *The New York Times*, July 26, 1972.

Twenty-eight of the men had died directly of syphilis, 100 were dead of related complications, 40 of their wives had been infected, and 19 of their children had been born with congenital syphilis. [142] As part of a settlement of a class action lawsuit [143] subsequently filed by NAACP, nine million dollars and the promise of free medical treatment were given to surviving participants and surviving family members who had been infected as a consequence of the study.[144]

The Tuskegee experiment represents an abuse of power by physicians in the face of illiterate minority patients.[145] One attorney who represented the patients and their survivors commented on the illiteracy of the patients' descendants, which he discovered while attempting to identify potential beneficiaries of the legal settlement:

> Perhaps the most distressing thing [attorneys] Gray and Carter encountered was the lack of social and economic mobility among the heirs. "There were more people who had to execute document by making marks than I'll ever see the rest of my life," Carter recalled. "It didn't matter whether they had gone to Cleveland or stayed right here, so many of them were illiterate and uneducated."[146]

One good consequence of the experiment was the push within the then Department of Health, Education and Welfare (HEW) to study the ethical principles involved in such human experimentation and to issue guidelines applicable to all institutions proposing to perform such research. A blue ribbon commission was established by HEW and was directed to consider:

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[142] James H. Jones, *Bad Blood, the Tuskegee Syphilis Experiment*. New York, 1981

[143] *Pollard v. U.S.*, 384 F. Supp. 204 (M.D. Ala, 1974) and *Pollard v. United States*, 69 F.R.D. 646 (M.D. Ala, 1976)

[144] An historic irony is the fact that The Department of Health and Human Services which was tasked with the responsibility of providing for the health care needs of the men in the experiment contracted with the Alabama Department of Health to provide some of the home health and transportation services the men have needed over the last decade or so. The writer herein negotiated some of those contracts.

[145] McClellan, Frank, Medical Malpractice Law, Morality And The Culture Wars A Critical Assessment Of The Tort Reform Movement, 27 Journal of Legal Medicine 33.

- the boundaries between biomedical and behavioral research and the accepted and routine practice of medicine;
- the role of assessment of risk-benefit criteria in the determination of the appropriateness of research involving human subjects;
- appropriate guidelines for the selection of human subjects for participation in such research; and
- the nature and definition of informed consent in various research settings.[147]

The report was finished on April 18, 1979, and gets its name from the Belmont Conference Center where the document was drafted. Belmont, which at one time belonged to the Smithsonian Institution, is located in Elkridge, Maryland, close to Baltimore.

The Tuskegee Experiment was not the first widely publicized abuse of human subjects to draw widespread attention and to beg corrective action. In the wake of atrocious tales of human experimentation by the infamous Dr. Mengele for Hitler in World War II, the Nuremberg Code was written to set standards for the judging of the *ex post facto* conduct of physicians and scientists in the war. The Nuremberg Code, though a retrospective, nevertheless became the "prototype" for several later codes that had a prospective application. The Nuremberg Code divided the field into three broad areas of scope: boundaries between practice and research; basic ethical principle; and practice.

Building upon the Nuremberg foundation, the World Medical Associated in 1964 drafted the *Declaration of Helsinki.* Named for the meeting place, Helsinki, Finland, the Declaration established informed consent as the ethical standard in research while allowing for "surrogate" consent in appropriate cases. The Declaration also enunciated

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[146] Fred D. Gray, The Tuskegee Syphilis Study: The Real Story and Beyond (1998).

[147] *The Belmont Report*, "Ethical Principles and Guidelines for the Protection of Human Subjects of Research." The Report of the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research. Two volume set, DEW Publication No. (OS) 78-0013 and No. (OS) 78-0014

the principle that research should only be performed when it is “necessary to promote the health of the population represented.”

The Helsinki Declaration laid the foundation for the establishment by the Belmont Report of Institutional Review Boards. The Belmont Report builds upon this base and continues it placing the general principles more in utilitarian categories.

In 1991, fourteen federal agencies [148] joined HHS in adopting the uniform set of guidelines for human research and the protection of human subjects. This today is known as the “Common Rule,” and is the standard for all agencies and institutions performing such research.[149]

Boundaries between practice and research - According to Belmont, “practice” refers to interventions designed to “enhance the well-being” of the individual while “research” applies to the process to test an hypothesis, permit the drawing of conclusions therefrom and thus contribute to generalizable knowledge.[150] This definition needs to be borne in mind as the place of the research has changed over the years. Research is no longer carried on only in teaching institutions and academic medical facilities.[151] One

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[148] Departments of Agriculture, Energy, Commerce, Housing and Urban Development, Justice, Defense, Education, Veterans Affairs, Transportation; NASA, Consumer Products Safety Commission; Agency for International Development; EPA; NSF and CIA. Social Security follows HHS regulations.

[149] See 45 CFR Part 46 of HHS regulations.

[150] 45 C.F.R. '46.102(e) and (f) and 21 C.F.R. 46.102(e) and (f). The writer herein, as chair of the Department’s Institutional Review Board, reviews many projects which appear to be research, but are in fact merely what amounts to quality control of the Department’s strategic individual treatment interventions. That is not research and IRB rules do not apply.

[151] Teresa A. Williams, *et al*. for the American Health Lawyers Association, *Institutional Review Boards: A Primer*, Washington, DC, 2007.

author estimates that there are as many as 19,000,000 individuals participating in research in a given year.[152]

The heart of our consideration herein is the second portion of Belmont as informed by Nuremberg – ethical principles. These principles, though specifically applicable to research involving human subjects sound very much like basic human rights statements – and so they are. Belmont renders three basic principles: respect for persons, beneficence and justice.

Respect for persons is an eagle with two wings. First that persons should be treated as autonomous agents[153] and second that persons with diminished capability for autonomy must be protected by society. Autonomous persons have the right to have their opinion consulted in matters that relate to themselves. To make a fair judgment about such decisions, they must be given accurate information and must not be pressured into making decisions. One of the first things our IRB[154] looks at in an IRB submittal is the "informed consent." Is there one? Is it really "informed?" Does it give enough information, and is it understandable to the group under consideration? A further aspect of this is the requirement that this consent be periodically tested to make sure the subject still understands and still consents.

Beneficence requires the investigator to not only make sure there is continuing knowing consent, but to look out for the broader good of the subject. The investigator

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[152] Hazel Glenn Beh, "The Role of Institutional Review Boards in Protecting Human Subjects: Are We Really Ready to Fix a Broken System?" 26 Law & Psychology Review 1 (Spring 2002).

[153] Does this strangely give reminiscence to the Declaration of Independence, *q.v., supra.*

[154] IRB means the same thing as "institutional review committee" under the Food, Drug and Cosmetic Act. See Robert J. Levine, *Ethics and Regulation of Clinical Research* (1986).

starts with a borrowing from Hippocrates[155] and "does no harm" and then move past this to attempt to maximize the benefit to the individual subject. In other words, this principle requires the investigator not stop at merely doing no harm because as the research progresses, what is considered "harm" can change based on facts learned.

A thorny ethical controversy involves questions of whether it is a valid subject of beneficent research where there is little or minimal risk to the subject balanced against substantial benefit to generalizable knowledge or even to identifiable groups.

The principle of justice applies to the allocation of risk and benefit to the subjects and to the expected served populations. To explain, it can be said that there are several formulations for distributing the benefits and burdens of research: to each person an equal share, to each person according to his or her need, to each person according to societal contributions past and future or to each person according to merit.[156]

An example of the justice principle is the question of how the researcher goes about selecting the subjects for the research. Are these welfare patients, from a particular socio-economic or ethic background, confined populations such as prisoners? If so, the selection process of the subjects would give me pause as an IRB chair. The reverse application of the principle is true for the recipients of the benefit of the research. Is it going to benefit only a member of one of these groups or is it going to exclude systematically members of one of these or other groups?

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[155] See the discussion, *supra* as to whether Hippocrates actually said "first do no harm."

[156] We are going to see that some of these same ideas apply in our allocation of scare resources in a disaster. See *infra*.

As these principles work themselves out in the mechanics of application, there must be an informed consent,[157] a detailed analysis of the risk to benefit ratio and an analysis of the criteria for selection of the subjects of the research.

There are occasions when the revelation of the subject of the research would invalidate the outcome. In that case informed consent requires three things: 1) incomplete disclosure must really be necessary, 2) there would be no undisclosed risks that are more than minimal to the subject and 3) there is an adequate plan for debriefing subjects after the conclusion of the project.

The laying out of the risk to benefit ratio concerns itself with probabilities and "magnitude" of possible harm and anticipated benefits. Harm, of course can be more than merely physical. Consideration must also be given to psychological, legal, social and economic elements of the possible risk. These must then be balanced. To a great extent, the "balancing" is subjective but should be governed by a full knowledge of the ethical principles which underlie research itself.

The selection of subjects is accomplished principally according to the justice of the matter. This obtains on a social and an individual level. Individually, researchers should be fair with the subjects, telling the truth to them and not offering inflated goals or promises. Neither should promises or recruitment statements be used to encourage or discourage particular subjects.

Special care must be taken with confined or disadvantaged populations so as not to continue the over-burdening of such populations. In recruiting especially prisoners, special attention must be given to whether or not the "volunteers" are really volunteers.

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[157] See discussion *supra.*

The same can apply to service men and women. If they are allowed to perceive that they get a special benefit such as light duty or excuse from exercises because they participate, one should look carefully at the justice of such promises.

The Public Health Code of Ethics[158]

For a very thorough treatment of ethical concepts in public health in general written prior to 9/11 and the marriage of public health with disaster preparedness, I invite your attention to *Ethics and Public Health: Model Curriculum*, an online self-guided course sponsored jointly by HRSA, the Association of Schools of Public Health and the Hastings Center.[159] Funded by the CDC and the Public Health Leadership Society (PHLS), the Principles of the Ethical Practice of Public Health were developed by Center for Health Leadership and Practice, Public Health Institute and members of the PHLS ethics work group. [160]

Lawrence Gostin [161]tells us that in 2000, a "diverse group of public health professionals" [162]was convened to draft a code of ethics to guide the practice of public health. A year later, the code was reviewed by ethicists and practitioners and adopted as an official statement by the American Public Health Association in 2002. Other national public health organizations have since recognized the *Code.*

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[158] For an online version, see The University of North Carolina at Chapel Hill http://www.sph.unc.edu/ethics/code/code2.htm#code1

[159] See Bruce Jennings, Jeffery Kahn, Anna Mastroianni and Lisa S. Parker, editors, *Ethics and Public Health: Model Curriculum*, < http://www.asph.org/document.cfm?page=782 >

[160] See http://www.phls.org/home/section/3-26/.

[161] Lawrence O. Gostin, editor, *Public Health Ethics and Law: A Reader*. University of California Press, 2002), at Chapter 3, *Public Health Ethics: The Communitarian Tradition*

[162] It is the writer's herein great privilege to have been for many years a colleague of one of the drafters of the *Code*, Kathy Vincent of the Alabama Department of Public Health. The principal draftsman was Professor James C. Thomas of the Department of Epidemiology of the University of North Carolina School of Public Health.

In its Preamble, this *Code* sets forth an interesting manner of self-interpretation. The *Code* states what the drafters believe to be key principles of the ethical practice and then attach a statement listing the key values and beliefs upon which the ethical principles are based. An important underlying definitional understanding is the *Code's* affirmation of the World Health Organization's understanding of the term "health." WHO defines "health" as "a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity."[163]

The *Code* settles on twelve *Principles of the Ethical Practice of Public Health***.**

1. Addresses fundamental causes of disease, aiming at prevention.
2. Respects the rights of individuals in the community.
3. Utilizes community input to develop policies, programs, and priorities.
4. Advocates for the "empowerment" of the disenfranchised community.
5. Seeks the information needed before acting.
6. Provides the community with information to make decisions.
7. Acts in a timely manner on the information.
8. Incorporates a variety of approaches that anticipate and respect diversity.
9. Implements programs/policies to enhance physical and social environment.
10. Confidentiality - Exceptions must be justified on the basis of the high likelihood of significant harm to the individual or others.
11. Professional competence.
12. Work collaboratively to build the public's trust.

In its "value and belief section," the *Code* reaffirms the Universal Declaration of Human Rights[164] stating that "everyone has the right to a standard of living adequate for

[163] See: WHO. Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June 1946, and entered into force on 7 April 1948.
[164] On December 10, 1948 the General Assembly of the United Nations adopted and proclaimed the Universal Declaration of Human Rights.

the health and well-being of himself and his family." Other underlying values and beliefs inform their Twelve Principles. "Humans are inherently social and interdependent," they hold, thus the principle of "community." Community is perpetually balanced as against the rights of the individual. Therein is a major tension.

Another underlying concept is the idea of public trust. Any institution whether public or private will always be hampered in its work if the public doesn't trust it. Part of that trust is the principle of allowing the community to comment on policy decisions.

Likewise, collaboration among not only institutions but with stake-holders is a key element to public health. The *Code* observes that "[p]eople and their physical environment are interdependent. A detriment to one flows backward to the other. These should not be viewed as separate societal goals."

The *Code* also is upheld by the science of prevention and the appropriate gathering, use and dispersion of knowledge. Lastly, the *Code* requires *action*. It is axiomatic that all the knowledge in the world is of little value if public health does nothing constructive with it.

> Public health is active rather than passive, and information is not to be gathered for idle interest. Yet the ability to act is conditioned by available resources and opportunities, and by competing needs. Moreover, the ability to respond to urgent situations depends on having established a mandate to do so through the democratic processes . . .[165]

Public Officer and Employee Ethics laws

The *Code of Alabama, 1975,* typical of public ethics section, reads :

> (a) No public official or public employee shall use or cause to be used his or her official position or office to obtain personal gain for himself or herself, or family member of the public employee or family member of the public official, or any business with which the person is associated unless the use and gain are otherwise

[165] Notes, paragraph 7 at *Public Health Code of Ethics*.

specifically authorized by law. Personal gain is achieved when the public official, public employee, or a family member thereof receives, obtains, exerts control over, or otherwise converts to personal use the object constituting such personal gain.[166]

The key provision to such ethics is the idea of prohibiting the using of one's public position for personal gain. While some state ethics laws go further, many don't. The Alabama Ethics law, according to the current State Ethics Commissioner was, in the wake of Watergate, "conceived in a cavalier game of 'chicken' between the state Senate and House of Representatives."[167] Further, Melvin G. Cooper, the first Alabama Ethics Commissioner tells us that in 1970, after the legislature had passed the bill, no one expected the then Governor George C. Wallace to sign it. However, on the day after it was passed by the second house, Governor Wallace did sign it very early in the morning before any of the legislators who had passed it could attempt to persuade him not to. Mr. Cooper later learned from Governor Wallace that "the Guvnuh" was so sure that the legislature would not pass such an act that he stated on the first day of the session that if they did pass such an act, he would sign it "without even reading it." Mr. Cooper states that Governor Wallace told him privately that such was exactly what he did – or didn't do as the case was.[168]

The point of this story from Alabama political lore is that typically public ethics laws are *very narrowly crafted* for the very good political reason that they apply to the men and women who pass them and if those men and women are not politically careful, they can become their own executioner. Thus, public ethics laws in exquisite contrast to the foregoing *Code of Public Health Ethics*, deal with unitary issues such as Alabama's not

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166 *Code of Ala.1975*, § 36-25-5

167 James L. Sumner, Jr., "The Alabama Ethics Law: A Retrospective," The Alabama Lawyer, July, 1999.

using your public office for personal gain. There are many, many practices that could go on in a state government which would violate ethical principles established since the time of Moses but which are not forbidden or even addressed in public ethics laws. Remember that codes of ethics written by professional organization like the American Public Health Association are guiding lights, the violation of which makes you feel bad. However the violation of public ethics laws sends you to jail.[169] Wible's sarcastic "First Law of Political Science" should also be consulted: "Ethics laws apply in *inverse proportion* to the amount of money that you can actually steal." It is interesting to note that high political leaders rarely go to jail for violations of Ethics laws, instead when that happens, they are usually tripped up on some other charge as in the case of Governor Don Siegelman. The exception to that rule is former Governor Guy Hunt who was actually convicted in 1993 of ethics violations involving the use of the state airplane for private preaching trips. It is interesting to note that in 1997, he received a full pardon from the State Board of Pardons and Paroles. Subsequently, the legislature urged upon Governor Riley that he be named to the position of "Governor's Counselor." Today a rest stop is named in his honor near mile marker 300 at Cullman, his hometown[170] on I-65.[171]

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[168] See: Melvin G. Cooper, "Alabama's Ethics Law: Closing the Loopholes" in "Alabama Issues, 2002," Jim Seroka and Thomas Vocino, editors. (Auburn University at Montgomery, 2002).

[169] One famous Alabama elected official, State Public Service Commission President, Juanita McDaniel, was convicted of using her public office for personal gain by using false expense accounts. She was sentenced to prison in 1980. See the previous note. What the article cited therein doesn't tell you is that she served her time in the State's newest city jail in Fort Deposit, population about 1043, and that the doors to her cell were never locked, *a l* ㄴOtis of *Andy Griffith* fame. Further, while in jail, she, affectionately known as "'Nita," was a member in good standing of the Bethel Baptist Church's ladies' Sunday School class and regularly hosted class meetings in the kitchen of the new city jail. My Aunt, the late Sue Priester, was a member of that class and tells this story as a part of our family history.

[170] Actually, Holly Pond, Alabama.

[171] See HJR 126, Special Session 2007 according to "The Alabama Scene," a column by the late political analyst, Bob Ingram, published in numerous Alabama papers on March 15, 2007.

VI. The Eye of the Storm – What Really Happens in A disaster

- **What really happens in a disaster?**
- **How do people's relationships change?**
- **Do people think and react differently?**
- **Are the consequences the same as if you had reacted "in the sunshine?"**
- **Are there really "no rules?"**
- **How can you "rank" people?**
- **Can you invoke "altered standards"?**
- **What are the rights of staff to desert?**

The following article appeared in the *Daily Reveille* on July 20, 2006:[172]

> A doctor and two nurses were arrested Monday for allegedly practicing euthanasia at Memorial Medical Center in New Orleans in the days following Hurricane Katrina.
> The three medical staffers were each arrested for second-degree murder. The three are accused of injecting patients with lethal doses of Morphine and Versed.
>
> 'This is not euthanasia. This is homicide,' Attorney General Charles Foti said. "We're talking about people who pretended that maybe they were God."
>
> … The trio allegedly intentionally killed multiple patients by administering or helping administer lethal doses of the two drugs. The investigation was sparked following Katrina and eventually led to a Lifecare Hospitals statement that reported possible euthanasia of patients at Memorial Medical Center.
>
> [The Hospital stated:] 'I believe this case is a strong one and that these charges are based on sound legal and medical evidence. … While I am aware of the horrendous conditions that existed after Hurricane Katrina, … I believe that there is no excuse for intentionally killing another living human being.'
>
> … [A]ccording to LSU associate sociology Professor Sung Joon Jang, [he] believes the three accused were likely trying to help and meant no ill harm.
>
> 'Their motive was to do something good,' Jang said. 'At the time it was probably their best judgment. Of course when you do something like this, it brings in the moral and physiological principles and legal questions that must be addressed. No matter what their decision, their motives could have still been questioned.'
>
> … Jang believes the accused three were acting out of compassion, but in Louisiana, euthanasia is against the law. 'The fact is, the law was broken and it is my job to seek justice for the victims in this case,' [Louisiana Attorney General Charles] Foti said. 'It gives me no pleasure to report what happened here today and my heart goes out to the families and loved ones of those victims.'

That's the newspaper report. A January, 2008 article in the New England Journal of Medicine gives much more insight into the chaos that grew over a 2- day period.

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[172] See David Brennan, "3 Arrested in Katrina Euthanasia." *Daily Reveille*, Louisiana State University, July 20, 2006.

> By the morning of Thursday, September 1, about 25 of the sickest patients in the complex had been evacuated by helicopter, and staff members were moving other patients, including some LifeCare patients, to staging areas to await evacuation by helicopter or boat. The staff apparently decided that these nine could not be rescued, but it is unclear who made that decision and whether it was based on the patients' medical conditions, their resuscitation status (five of the nine reportedly had do-not-resuscitate [DNR] orders), or other considerations. According to written responses that Pou provided for this article, "The standard of rescue [had] changed from Tuesday to Thursday; initially the sickest patients were evacuated first. When we realized that help was not imminent, . . . the standard of rescue changed to that of reverse triage. It was recognized that some patients might not survive, and priority was given to those who had the best chance of survival. On Thursday morning, only category 3 patients [the most gravely ill] remained on the LifeCare unit."[173]

Note that the standard of *rescue* changed and triage became *reverse*. Chaos ensued.

In January 29, 2007, the staff members were fired from their jobs. In March of 2007, their case was presented to a special grand jury. [174] On July 3, 2007, the Grand Jury returned a "no bill." [175] On August 16, 2007, the New Orleans court expunged Dr. Pou's record with a promise to do the same for the nurses.[176] In June of 2008, the Louisiana Legislature passed three measures designed to reform the review of the decision making process for medical personnel in disasters.[177]

Obviously, we have now turned our attention from the theoretical to the practical – in fact to the deadly serious. It is here where we have "quit preachin' and gone to

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[173] Okie S., Dr. Pou and the hurricane -- implications for patient care during disasters. N Engl J Med 2008;358:1-5.

[174] http://www.modernhealthcare.com/apps/pbcs.dll/article?Aid.=/20070327/FREE/70326009/0/FRONTPAGE "Reporter's Notebook: It's Slow, But There Is Progress in New Orleans," Modern Healthcare, 27 March 2007

[175] Gwen Filosa and John Pope, "Grand jury refuses to indict Dr. Anna Pou ." New Orleans Times-Picayune July 24, 2007

[176] Laura Maggi , "Judge expunges record of Memorial physician Tenet seeks return of hospital documents," New Orleans Times Picayune, Friday, August 17, 2007

[177] Act No. 2008-538 provides certain immunities for medical personnel in evacuations situations; Act No. 2008-539 provides similar civil immunities in disasters; and Act No. 2008-758 establishes a review process to be engaged before criminal charges may be preferred based on medical decisions made during a disaster.

medlin.'" A number of questions come to mind and these questions will underlie the remainder of the paper.

- What really happens in a disaster?
- How do people's relationships change?
- Do people think and react differently?
- Are the consequences the same as if you had reacted "in the sunshine?"
- The "Outback Steakhouse Question," are there really "no rules?"
- How can you "rank" people in order or precedence to receive vaccine, ventilators or treatment according to ethical principles?
- Can you invoke "altered standards of care?
- What are the rights of staff to desert, *vel non*?

What happens in a disaster? CERT Training from FEMA[178] tells us what we really already know. Disaster survivors normally experience a range of psychological and physiological reactions, the strength and type of which depend on several factors: prior experience with the same or a similar event; intensity of the disruption; length of time that has elapsed between the event occurrence and the present; individual feelings that there is no escape, which sets the stage for panic; and the emotional strength of the individual. [179] Studies have shown that their reactions go through stages and that their reaction to workers vary according to the stages from exuberant following of instructions to disbelief and disgruntlement.

Psychologically, they may be subject to certain physiological and physiological symptoms including: irritability or anger; denial; loss of appetite; self-blame; blaming others; mood swings; headaches; chest pain; isolation; withdrawal; diarrhea, stomach pain; nausea; fear of recurrence; hyperactivity; feeling stunned, numb, or overwhelmed; increase in alcohol or drug consumption; feeling helpless; nightmares; concentration and

[178] CERT Participant Manual, Unit 7. http://www.citizencorps.gov/cert/downloads/training/PM-CERT-Unit7Rev3.doc
[179] Id.

memory problems; inability to sleep; sadness, depression, grief; fatigue and low energy.[180] For our purposes, we know that disaster workers *may* go through many of the same symptoms leading to the conclusion that *in the end, they may become "stressed out" and may make bad choices and the wrong decisions.*

And what of the consequences, are they the same as if one had reacted "in the sunshine" rather than in the storm? Related is the asking of the "Outback Steakhouse Question," are there really "no rules?" While it may depend on what you did, who you did it to, [181] how bad it was and most importantly, who saw you do it, [182] these questions are answered, "yes and no." "Yes," in the aftermath of the storm, the consequences *may* be the same as if you had done it in the sunshine and "no," there is never a situation where there are "no rules." [183]

Ask the healthcare workers in the scenario above if there are consequences that flow from their actions in the Eye of the Storm and ask the Honorable Charles Foti, Louisiana Attorney General, if there were no rules.

Let's now attack perhaps the hardest concept governing what can and cannot happen: will euthanasia *ever* be an option? Perhaps the ethical issues of this could be debated for a long time given what we have already learned about the balance between the *right to life* [184] and the sometime morally acceptable *taking of life*.[185] I would submit that this issue will not be solved in the church but in the courtroom. In today's political

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[180] Id.

[181] Invoking the *Golden Rule, q.v.*

[182] This invokes the "Bart Simpson Defense," nobody saw me do therefore, I didn't do it.

[183] Except at the *Outback Steakhouse* and even then, I hope they are subject to health department rules for food service establishments

[184] See the discussion at the *Declaration of Independence, supra.*

climate, it's going to be *very, very* difficult, if not impossible, to *ever* write a scenario that would justify euthanasia or assisted suicide, except in Oregon, and now Washington State,[186] the only states officially sanctioning "assisted suicide." In Oregon,

> (1) An adult who is capable, is a resident of Oregon, and has been determined by the attending physician and consulting physician to be suffering from a terminal disease, and who has voluntarily expressed his or her wish to die, may make a written request for medication for the purpose of ending his or her life in a humane and dignified manner in accordance with ORS 127.800 to 127.897.[187]

The Oregon statute has been upheld by the U.S. Supreme Court at least against a procedural challenge where the Attorney General filed suit to have the statute ruled unconstitutional based on conflict with the federal Controlled Substances Act (CSA). [188] The High Court held that the CSA did not authorize Attorney General to prohibit doctors from prescribing regulated drugs for use in physician-assisted suicide, as authorized by ODWDA.

However, as seen, *supra*, when such decisions are presented to grand juries, depending on the facts, though the act may violate the state's criminal law, the grand jury may not indict.[189] Even if they do indict, petit juries may not convict.[190] In discussing such weighty matter from the judicial perspective, one is led to the problem of assuming this terrible decision is ethically acceptable, can it be legally done? This brings up

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[185] See the discussion on the concept of *jus ad bellum, supra.*

[186] Jane Gross, "Landscape Evolves for Assisted Suicide," *New York Times*, November 10, 2008.

[187] *Oregon Revised Statutes* 127.801, known as the Oregon Death with Dignity Act (ODWDA.)

[188] 84 Stat. 1242, as amended, 21 U.S.C. § 801 et seq.

[189] See notes 136 and 137.

[190] Reference the September, 2007 acquittal of New Orleans area nursing home owners, Sal and Mabel Mangano, in their failure to evacuate the nursing home in the wake of the Katrina flood. See Nossiter, Adam, *Nursing Home Owners Acquitted in Deaths*, New York Times, September, 8, 2007.

perhaps the most important balancing test in Constitutional Law, the balance of the rights as against the rights of the society to preserve itself and the other people in it.

Before we get to the right to *life,* [191] let's first look at the issue of whether government can even address the question at all. The landmark case from public health standpoint is a case which involved required vaccination for smallpox, *Jacobson v. Massachusetts.*[192] *Jacobson* is such an important case for public health that CDC recently held a workshop to celebrate the 100 year anniversary of this case.

Henning Jacobson, a prominent local preacher, refused to be vaccinated after the City of Cambridge, Massachusetts. passed an ordinance finding "smallpox prevalent in the city and continues to increase" and directing "vaccination of all inhabitants of city except children who present a certificate signed by physician that they are unfit subjects of vaccination."

State law authorized city boards of health to require and enforce vaccination and specified a fine of $5 for anyone who refused to comply. Jacobson refused and was fined, and took his case to Massachusetts Supreme Court and then to U.S Supreme Court which held:

> ["The p]olice power of state must be held to embrace, at least, such reasonable regulations established directly be legislative enactment as will protect the public health and safety. . . .The mode or manner in which those results are to be accomplished is within discretion of the state, subject, of course, that . . . no rule . . . or regulation . . . shall contravene the Constitution of the United States, or with any right which that instrument gives or secures." [193]
>
> "The liberty secured by the Constitution of the United States to every person within its jurisdiction does not import an absolute right in each person to be, at all times and in all circumstances, wholly freed from restraint. There are

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[191] In terms of terms the termination of a "life in being," pretermitting the thorny question of when does life begin?

[192] 197 U.S. 11 (1905)

[193] Id. at page 25.

> manifold restraints to which every person is necessarily subject for the common good."
>
> Real liberty for all could not exist if each individual can use his own, whether in respect of his person or property, regardless of the injury that may be done to others. . . . Upon the principle of self defense, of paramount necessity, a community has the right to protect itself against an epidemic of disease which threatens the safety of its members." [194]

In affirming Massachusetts' compulsory vaccination law, the Court found this a legitimate use of state powers and established a floor of constitutional protections that consists of four standards: necessity, reasonable means, proportionality, and harm avoidance.

The Court would look into the question of whether the course of action involves "rights" of an individual and if so whether those rights are "fundamental" or not. If the rights are merely rights secured by law, the state can intervene to place some limits on those rights if the state's action is "reasonably related to a legitimate government". If, on the other hand, the heart of the question involves a right that is deemed to be "fundamental," the state cannot violate that right.[195]

Writing a comment on the case of *Gonzales v. Raich* [196] in the *Fordham Urban Law Journal*, [197] Adam Hyatt commenting upon the situation in New Orleans raised in the introduction to this section, concludes that even in such dire circumstances, the High Court would not be able to find an ethical basis for such actions, perhaps he adds, even "in the case of extreme circumstances and … a compelling government interest." [198]

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[194] Id. at pages 26-27.

[195] See *Reno v. Flores*, 507 U.S. 292, 302 (1993). See also *Washington v. Glucksberg*, 521 U.S. 702, 728(1997).

[196] 125 S. Ct. 125 (2005)

[197] 33 Fordham Urb. L.J. 1345

[198] Id. at page 11.

Granted, for the sake of argument, "we can't volitionally *kill* people,[199] what is the ethical justification for taking those other decisions that have the effect of determining who will have the opportunity to remain alive in the disaster and who won't, decisions involving triage and the allocation of scarce resources: vaccine, [200] treatment modalities and supplies such as ventilators and personnel? Would we be legally authorized and ethically sound in altering the standard of care?

VII. Triage, Egalitarianism and Utilitarianism

Human beings have been thinking and writing about ethics in general, disaster management in particular, and the application of ethical ideas to public policy for as long as we have been thinking and writing. Literally 5,000 years ago, the Egyptians struggled with their idea of *maat* - by which they meant the appropriate good order of society - and the role of the Pharaoh in preserving or restoring it when the annual Nile floods got out of hand. [201]

Later – much later - the English philosopher Jeremy Bentham claimed that public policy should "maximize the good across the greatest number." Utilitarian theory, or

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[199] If we were only discussing chickens . . . The USDA Animal and Plant Inspection Service (APHIS) has detailed plans stating that it is not only acceptable but *required* practice to *depopulate* (read that, *kill*) chickens in an avian influenza episode. See http://www.avma.org/issues/policy/poultry_depopulation.asp

[200] WHO's global pandemic influenza plans calls for readiness, including enough vaccine, within ten years. See: WHO Global Influenza Action Plan to Increase Vaccine Supply, WHO/IVB/06.13; (September, 2006) WHO/CDS/EPR/GIP/2006.1. Available online at www.who.int/vaccines-documents/

[201] Marc Roberts, Ph.D., Harvard University and James G. Hodge, Jr., J.D., LL.M., Georgetown and Johns Hopkins Universities *et al.*, Agency for Healthcare Research and Quality, Office of Preparedness and Emergency Operations, Office of Public Health Emergency Preparedness: "Bioterrorism and Other Public Health Emergencies, Tools and Models for Planning and Preparedness," Chapter 2, "Ethical ideas as a Resource for Disaster Preparedness."

what is often referred to as consequentialist ethics, assesses what is right or good based on whether the consequences of the actions to be taken will be good. [202]

In contradistinction to Bentham's utilitarian view of the world – and in our case of disasters Immanuel Kant [203] propounded an egalitarian theory known formally as "deontology," or duty-based ethics. This theory focuses on non-consequentially based notions of good. In duty-based ethics, deciding what is right or good is based on meeting duties and obligations. [204]

The term, *Triage*, [205] was a French military medical term based on the Benthamite utilitarian principles of trying to achieve the most good for the most people. It has been adapted to modern military *and civilian* medicine.[206]

Originally, triage grouped casualties into four groups based on care needed and typically in this order: immediate, minimal, delayed and expectant. The use of triage, according to Professor Orr from the University of Vermont, must be done without regard to rank, age, race, social worth or income. It is thus based, he holds, not on the social worth of the individual, but on societal need.[207]

Professor James Tabery states that in regard to the ethics of triage in disaster situations there has been or is in the process of becoming a switch from standard medical ethics with the primary focus on *individual autonomy* to an ethics of public health with a

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[202] Jeremy Bentham*, Introduction to the Principles of Morals and Legislation*, a work written in 1780 but not published until 1789.

[203] Discussion, *supra., q.v.*

[204] Immanuel Kant, *Groundwork of the Metaphysics of Morals* (Grundlegung zur Metaphysik der Sitten (1785).

[205] Meaning "to sort out."

[206] Robert D. Orr, Director of Ethics, Fletcher Allen Health Care. "Ethical Issues in Bioterrorism," prepared in association with the University of Vermont College of Medicine (2003.)

primary focus on the *health of the community*, with the overarching goal being to *minimize morbidity and mortality during the pandemic.*[208] Professor Tabery then takes the Bentham/Kant debate into the 21st Century in looking at models for triage: *Utilitarian v. Egalitarian.* In other words, given scarce resources, do the workers address the needs from the basis of for whom they can do the *most good*, or to those who are in *greatest need*?

Of the utilitarian model, he observes that the goal is to help those for whom you can do the *most* good following the long-established standard in military medicine and in aspects of the healthcare industry. He quotes:

> "…triage decisions regarding the provision of critical care should be guided by the principle of seeking to help the greatest number of people survive the crisis…the most ethical way to help the greatest number of critically ill people survive in such dire conditions is to give such interventions first to the people deemed most likely to survive." [209]

He notes advantages: this plan follows a clear, simple, community-recognized goal in a potentially chaotic environment. However, it has disadvantages: situations will arise with no clear utility-based answer apparent that may lead to "unintended, insidious discrimination (examples: ageism, sexism, racism.)"[210]

Tabery notes the *egalitarian* model with its goal to help those in *greatest need.* This method ranks patients based on severity of illness, with patients in the most severe condition receiving the medical attention. He points out that the ultimate goal such as

[207] Id. at page 2.

[208] Professor James Tabery, Univ. of Pittsburgh, Dept. of History and Phil. of Science, Center for Bioethics and Health Law, in a lecture to Muhlenberg College delivered November 27, 2006 entitled "Pandemic Flu: Lessons from the Past, Prospects for the Future,"

[209] University of Pittsburgh Working Group on Emergency Mass Critical Care (2005)

[210] Tabery at note 15.

limiting morbidity and mortality during the pandemic is *de-prioritized* in order to preserve the egalitarian treatment of patients throughout the crisis.[211]

Of course, there would always be the "first come-first served" method, but we can see how that would break down almost immediately in a disaster or pandemic.

So far, Tabery has summarized history. Now, he gives us something new: the *hybrid approach.*[212] This approach draw on virtues of both the utilitarian and egalitarian models yet follows the utilitarian model, recognizing the public health goal of minimizing morbidity and mortality during the pandemic. [213] In other words, one uses a utilitarian approach but with egalitarian methods.

There are a number of disaster triage methods suggested by various authors. They typically involve "sorting out" patients into 3 or 4 groups. CERT training[214] utilizes 3 groups: immediate, delayed and dead. This method does not address extremely scarce resource scenarios. Neither does the Ontario Provincial Health Plan[215] which utilizes 4 groups based on a sequential organ failure assessment (SOFA) with patients tagged: red – highest priority for care; yellow – next priority; blue- care and discharge; green – defer or discharge.

A very commonly used method by pre-hospital EMS personnel is the START method – *simple triage and rapid treatment* based on three primary observations:

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[211] Tabery at note 16.
[212] Tabery at note 17.
[213] The goals of the Federal response to an influenza pandemic include to: (1) Stop, slow, or otherwise limit the spread of the pandemic to the United States; (2) limit the domestic spread of the pandemic and mitigate the disease, suffering, and death; and (3) sustain infrastructure and mitigate impact to the economy and functioning of society
[214] Community Emergency Response Team Training No. IS-317, Module 4, Lesson 13 (March 2004)
[215] Michael D. Christian, *et al.* "Development of a triage protocol for critical care during an influenza pandemic." CMAJ 2006;175 (11)1377-81.

Respiration, Perfusion, and Mental Status (RPM). Patients are tagged for easy recognition. The Four Colors of Triage are green - delayed care / can delay up to three hours; yellow - urgent care / can delay up to one hour; red - immediate care / life-threatening and black - victim is dead / no care required.[216]

In the hospital emergency department something similar to the following five category triage categories is typically used. [217]

- **Triage category 1:** need for resuscitation - patients seen immediately. People in this group are critically ill and require immediate attention. Most arrive at the emergency department by ambulance. This group includes people whose heart may have stopped beating, whose blood pressure may have dropped to dangerously low levels, who may be barely breathing or have stopped breathing, who may have suffered a critical injury or who may have had an overdose of intravenous drugs and be unresponsive.
- **Triage category 2:** emergency - patients seen within 10 minutes. People in this group will probably be suffering a critical illness or very severe pain. For example, the group includes people with serious chest pain likely to be related to a heart attack, people with difficulty breathing and people with severe fractures.
- **Triage category 3:** urgent - patients seen within 30 minutes. People in this group include patients suffering from severe illnesses, people with head injuries but who are conscious, and people with major bleeding from cuts, major fractures, persistent vomiting or dehydration.
- **Triage category 4:** semi-urgent - patients seen within 60 minutes. People in this group usually have less severe symptoms or injuries, although the condition may be potentially serious. Examples include people with mild bleeding, a foreign body in the eye, a head injury (but where the patient never lost consciousness), a sprained ankle, possible bone fractures, abdominal pain, migraine or earache.
- **Triage category 5:** non-urgent - patients seen within 120 minutes. People in this group usually have minor illnesses or symptoms that may have been present for more than a week, like rashes or minor aches and pains. The group includes people with stable chronic conditions who are experiencing minor symptoms.

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[216] www.start-triage.com

[217] Quoted here is the state – approved triage policy from the State of Victoria, Australia. Source: State of Victoria, Department of Human Services.

Writing for the *Journal of the Society of Academic Emergency Medicine*, [218] Dr. Burkle suggests what he calls the "SERV" method of triage for large bioevents such as an influenza pandemic. He points out that normal triage methods used in the E D or by medics in the field do not consider exposure, duration or infectiousness. Consequently, such methods do nothing to control disease transmission and delayed recognition of victims. Rather, he submits, the theory of triage should be altered to provide management based on what he calls "population control" with the goal of preventing secondary disease transmission. His detailed method corresponds to CDC phases of a pandemic disease outbreak.[219]

The Canadians, with some experience in mass infectious events, are developing a protocol for pandemic influenza triage.[220] In so doing, they used components from other types of triage plans, such as severity scoring systems. Their pandemic triage plan consists of four components: inclusion criteria, exclusion criteria, minimum qualifications for survival, and a color-coded prioritization tool.

The *inclusion criteria* identify patients who may benefit from critical care treatment, focusing on respiratory failure. The *exclusion criteria* is an ethically critical piece. It places patients in three categories:

- poor prognosis despite critical care,
- those whose care demands resources that can't be provided during a pandemic, and
- those who have underlying advanced medical conditions.

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[218] Frederick M. Burkle, Jr., "Population Based Triage Management in Response to Surge-capacity Requirements during a Large-scale Bioevent Disaster. Doi: 10.1197/j.aem.2002.06.040.
[219] Id. at page 1118.
[220] See: Christian MD, Hawryluck L, Wax RS, et al. Development of a triage protocol for critical care during an influenza pandemic. CMAJ 2006;175(11):1377-1381.

The "minimum qualifications for survival" component attempts to place a limit on the resources used for any one patient. "This is a concept foreign to many medical systems in developed countries but one that has been used in war zones and refugee camps," they say.[221]

I would submit that to avoid utter chaos, in a facility assaulted by an influenza pandemic, one of these or a similar method would have to be used as a basis for triage procedures and then modified to include those who are not tagged black – dead – yet, but who are probably going to die despite perhaps heroic methods. Obviously, by this stage of the game, there is no time or resources for heroic methods to be used on patients who are probably going to die any way – hence the ethical debate.

Whatever method is decided upon, may I offer several points:

It needs to be decided *now*. Have a plan *now.*[222] It is a moral failure to put off such a momentous decision until there is no time to reach a *good* decision. Professor Tabery [223] urges the use of a *Triage Review Board* including an administrator, physicians, nurses, clergy, ethicists, and community persons at large to oversee the use of triage on a very frequent basis for practical as well as ethical reasons including the need to "engage the public" at pre, during, and post - stages of the pandemic or disaster. [224] At this point in the debate, the method *to be used*, if not *agreed upon* (and that is entirely possible that it will not be agreed upon,) should at least be formulated with wide input.

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[221] Melnychuk RM, Kenny NP. Pandemic triage: the ethical challenge. (Editorial) CMAJ 2006;175(11):1393.

[222] Coach Paul "Bear Bryant" is often quoted for the management technique: "have a plan, work your plan, plan for the unexpected."

[223] Cited, *supra.*

[224] Tabery at note 19.

The Alabama Department of Public Health is currently, as of this writing, developing a plan to assist hospitals in planning for, and conduct in, a disaster. This plan, though starting with a ventilator protocol, will ultimately deal with triage as well. In the Alabama plan, the criteria for disaster triage will be decided not on an institution-by-institution basis, but rather on a statewide basis developed by a large committee made up of members from a number of professions throughout the state.

The idea is that the criteria will ultimately be decided upon by the committee, approved by the State Health Officer with the support and input of the state hospital association and its member institutions and added as an addendum to the state's Emergency Operations Plan managed by the Emergency Management Agency.

The degree to which individual institutions must "adopt" the plan as their own or adopt one embodying the *concepts* of the plan and the degree to which the individual institutional plans may be at variance with the State plan is still unknown at this time. The plan from the American College of Chest Physicians suggests that there must be a single statewide plan and that facilities *must* follow that plan if they hope to have any legal immunity. The society suggests:

> While a proposed algorithm may need to be revised once the conditions of the mass casualty event are better understood, such revisions should be made uniformly, ideally by an expert group at the state or federal level that can integrate emerging data into the algorithm. *Ad hoc* departures from the algorithm are ethically and legally unwise.[225]

Executive orders would be written for the Governor to sign implementing the protocol in the proclaimed emergency. It is suggested by this author that the executive orders should also proclaim that hospital personnel functioning in accordance with the

EOP plan would be deemed to be "emergency management workers" and thus entitled to immunity for all but wanton and willful misconduct or bad faith.[226]

The Governor's Taskforce appointed by the Governor of the State of New York to examine such issues suggests a different path to granting protection to personnel following such altered standards and triage procedures. They recommend legislation would be the surest route to grant some immunity to those personnel.[227] They held:

> Legislation is the only avenue certain to provide robust protection for providers who adhere to the guidelines. Such legislation could offer immunity to health care providers who follow guidelines for ventilator allocation, or alternatively, could guarantee defense and/or indemnification to providers.

Alabama's justification in using a "top down" method rather than a "bottom up" method is one of practicality. It has become apparent that the plan must be proffered by those with expertise and perhaps more importantly, those whose *job it is to do this* for the task to ever be accomplished. While Professor Tabery's egalitarian ideas of the formation of such plans have great appeal to the sense of fairness and democracy in the community, Alabama has come to the conclusion that it just won't work that way. In other words, in an egalitarian-utilitarian debate on the formation of the plan, Alabama is utilitarian.[228]

Nevertheless, Professor Tabery's thoughts do have much to lend themselves to the utilitarian. He states that a good plan needs a Triage Officer – the initial person making these life and death decisions, needs to be a senior and well-trained individual, not a

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[225] See a full discussion of the Society's plan *supra.*

[226] See *Code of Ala. 1975* § 31-9-16.

[227] See Allocation of Ventilators in an Influenza Pandemic: Planning Document NYS Workgroup on Ventilator Allocation in an Influenza Pandemic NYS DOH/ NYS Task Force on Life & the Law. Comment Draft, March 2007, at page 3.

[228] See the discussion beginning at page 50.

neophyte.[229] Triage is not simple, it requires great skill, a certain "seasoned hardness" and perseverance.[230] It should be constantly reviewed during the implementation phase. The triage officer should be debriefed periodically by superiors and the whole process looked at on an on-going basis by the Triage Review Board.[231]

As alluded to previously, in the May 2008 issue of *Chest,* the Journal of the American College of Chest Physicians, the society publishes a broad strategy for the management of critical shortages in a catastrophic event.[232] There are four separate papers beginning with a statement of the issues and ending with the disaster protocol to be invoked by some government official, presumably the Governor by a declaration of a state of emergency after the trigger event has happened and after surge capacity has been reached and exceeded. Rationing would then take place according to the protocol. The critical care piece is summarized by the Society thusly:

> **Critical Care Resource Allocation**
> The task force advises rationing scarce critical care resources only after surge capacity has been exceeded and all attempts to use outside resources have been made. Under these circumstances, the task force proposes a formal EMCC triage and resource allocation protocol. Examples of the protocol include:
>
> - The hospital triage officer/team will assess and prioritize all patients for receipt of scarce interventions using objective medical criteria.
> - Palliative care for all patients will be a priority. However, patients will be ineligible for scarce critical care interventions if they have extreme organ failure and/or severe chronic illness with a short life expectancy.
> - Critical care resources will not be preferentially distributed to any specific population group.

[229] Thomas B. Repine, *Dynamics and Ethics of Triage: Rationing Care in Hard Times*, "Military Medicine"(June 2005) suggests
[230] J.C. Moskop, *A moral analysis of military medicine,* "Military Medicine" 1998; 163:76-79.
[231] Rapine and Tabery.
[232] "Definitive Care for the Critically Ill in a Disaster". *Chest*, Vol. 133, Number 5, supplement, May 2008.

- Decisions regarding resource allocation will be documented, remain transparent, occur uniformly across all affected regions, and subject to rigorous quality assurance. [233]

The fourth article gives the task forces' suggestions for the actual protocol.

In order to allocate critical care resources when systems are overwhelmed, the Task Force for Mass Critical Care Working Group suggests the following:

(1) An equitable triage process utilizing the Sequential Organ Failure Assessment scoring system;
(2) The concept of triage by a senior clinician(s) without direct clinical obligation, and a support system to implement and manage the triage process;
(3) Legal and ethical constructs underpinning the allocation of scarce resources; and
(4) A mechanism for rapid revision of the triage process as further disaster experiences, research, planning, and modeling come to light. [234]

As might be expected, the press,[235] at the time of this writing ridicules the planning document calling it "god-like" especially excoriating the categorizing of in a lower priority to receive scarce supplies:

People older that 85;
Those with severe trauma . . .;
Severely burned patients older than 60;
Those with severe mental impairment;
Those with chronic disease

Interviewed for the article, Lawrence O. Gostin, cited in several place in this paper with approval, points out the document, while being an important initiative, is a

[233] "EXPERTS ANNOUNCE NEW STRATEGY FOR DISASTER PREPAREDNESS: *New Disaster Proposal Could Legally Protect Physicians*." Press release, American College of Chest Physicians, May 5, 2008.

[234] Asha V. Devereaux, MD, MPH, FCCP; Jeffrey R. Dichter, MD; Michael D. Christian, MD, FRCPC; Nancy N. Dubler, LLB; Christian E. Sandrock, MD, MPH, FCCP; John L. Hick, MD; Tia Powell, MD; James A. Geiling, MD, FCCP; Dennis E. Amundson, CAPT, MC, USN, FCCP; Tom E. Baudendistel, MD; Dana A. Braner, MD; Mike A. Klein, JD; Kenneth A. Berkowitz, MD, FCCP; J. Randall Curtis, MD, MPH, FCCP and Lewis Rubinson, MD, PhD, "Definitive Care for the Critically Ill During a Disaster: A Framework for Allocation of Scarce Resources in Mass Critical Care", *Chest*, Vol. 133, Number 5, part 4.

[235] See: Lindsey Tanner, "Who Should MDs Let Die in a Pandemic? Report Offers Answers." Associated Press, May 5, 2008.

"political minefield and a legal minefield. He theorizes that the report "would probably violate federal laws against age discrimination and disability discrimination."

Indeed, the Americans with Disabilities Act (ADA) [236] may pose a significant barrier to the implementation of such criteria as might the Rehabilitation Act of 1973. [237] It is clear from § 12101 that the specific groups listed would fall within the "protected class" under the Act. If one is within the protected class, the Act prescribes:

> (a) No individual shall be discriminated against on the basis of disability in the full and equal enjoyment of the goods, services, facilities, privileges, advantages, or accommodations of any place of public accommodation by any person who owns, leases (or leases to), or operates a place of public accommodation.
>
> (b) (1) (A) (i) It shall be discriminatory to subject an individual or class of individuals on the basis of a disability or disabilities of such individual or class, directly, or through contractual, licensing, or other arrangements, to a denial of the opportunity of the individual or class to participate in or benefit from the goods, services, facilities, privileges, advantages, or accommodations of an entity.

It could be argued that there may be an exemption. Section 12812 (B) (2) (A) defines "discrimination" as follows:

> For purposes of subsection (a) of this section, discrimination includes
> (i) the imposition or application of eligibility criteria that screen out or tend to screen out an individual with a disability or any class of individuals with disabilities from fully and equally enjoying any goods, services, facilities, privileges, advantages, or accommodations, *unless such criteria can be shown to be necessary for the provision of the goods, services, facilities, privileges, advantages, or accommodations being offered*. . . (emphasis added.)

It could be argued that making criteria that have the effect of the elimination of services to certain "protected groups" is the only way the program can be run and is thus "*necessary for the provision of the goods, services, facilities, privileges, advantages, or*

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[236] 42 USC § 12101, *et seq.*
[237] 29 USC §701, *et seq.*

accommodations being offered." An analysis under the Rehabilitation Act of 1973 would probably tend toward the same result as an analysis under ADA.

Likewise 42 USC, §6101, *et seq*. proscribes discrimination on the basis of age in any federally assisted program.

> Sec. 6102. Prohibition of discrimination. Pursuant to regulations prescribed under section 6103 of this title, and except as provided by section 6103(b) and section 6103(c) of this title, no person in the United States shall, on the basis of age, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any program or activity receiving Federal financial assistance.

However, 42 USC § 6103(b)(1) gives an exception not unlike the ADA exception.

> Sec. 6102. Prohibition of discrimination. Pursuant to regulations prescribed under section 6103 of this title, and except as provided by section 6103(b) and section 6103(c) of this title, no person in the United States shall, on the basis of age, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any program or activity receiving Federal financial assistance.

Legal issues notwithstanding, [238]the Task Force Working Group strongly urged an ethical approach to the problem:

> **Limitation of Individual Autonomy:**
> The fair and just rationing of scarce resources requires public health decisions based on objective factors, rather than on the choice of individual leaders, providers, or patients. All individuals should receive the highest level of care given the resources available at the time.
>
> **Transparency:**
> Governments and institutions have an ethical obligation to plan allocation through a process that is transparent, open, and publicly debated. Governmental honesty about the need to ration medical care justifies institutional and professional actions of withholding and withdrawing support from individual patients. These restrictive policies must be understood and supported by medical providers and the public, ideally with reassurances that institutions and providers will be acting in good faith and legally protected in their efforts.

[238] Further legal analysis of the Society's proposition might take a whole "gaggle" of lawyers more time than the reader would care to view. But a number of other Acts could be called into play.

> **Justice/Fairness:**
> The proposed triage process relies on the principle of maximization of benefit to the population served. The triage process treats patients equally based on objective, physiologic criteria, and when these criteria do not clearly favor a particular patient, "first come, first serve" rules will apply. The triage process addresses only those in the acute hospital setting in need of the scarce resource and will not apply to individuals with long-term reliance on the scarce resource (*i.e.*, long-term mechanical ventilation) in a long-term care facility prior to the mass casualty event. Communities and states may have different approaches to these patients. These individuals will be subject to the triage process should they need acute hospitalization, and resources will be allocated according to predefined criteria. (Citations omitted.) [239]

Perhaps a more workable approach would be a less detailed approach embodying a protocol adopted by each facility after a model enunciated by the State and contained in the State Emergency Operations Plan.[240] CDC is currently studying the plan.[241]

Altered Standards of Care

The New York State Departments of Agriculture and Environmental Conservation estimate that in a "moderate" pandemic influenza event, patients will most likely utilize:

- 63% of hospital bed capacity;
- 125% of intensive care capacity; and
- 65% of hospital ventilator capacity.[242]

Thus, in a discussion of the ethical treatment of patients, we would be in a scarce resource situation; this leads to a discussion of the ethical and legal basis for *Altered Standards of Care*. When is it permissible from an ethical and legal standpoint to provide less than the care normally expected or held to be what is referred to in both the medical

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[239] See Asha V. Devereaux, et al., *supra.* at Suggestion 4.7
[240] At least, that is this author's construct of the idea.
[241] See John's Fifth Action Point: *Just Do It!*
[242] "Pandemic Influenza Plan Briefing," New York State Department of Agriculture and New York State Department of Environmental Conservation.

and legal professions as the standard of care?" To address this question, the Agency for Healthcare Research and Quality (AHRQ) and the Office of the Assistant Secretary for Public Health Emergency Preparedness (OASPHEP) within the U.S. Department of Health and Human Services (HHS) convened a blue ribbon working group. In their report,[243] they state the following finding, *inter alia*.

- The goal of an organized and coordinated response to a mass casualty event should be to maximize the number of lives saved.
- Changes in the usual standards of health and medical care will be necessary to allocate scarce resources in a different manner to save as many lives as possible.
- The basis for allocating health and medical resources in a mass casualty event must be fair and clinically sound.
- The process for making these decisions should be transparent and judged by the public to be fair.
- Protocols for triage need to be flexible enough to change as the size of a mass casualty event grows.
- Staff concerns must be addressed pre-event.[244]

The report then asks two questions that are of more concern for this ethical discussion: Is there adequate authority to activate this procedure and is it legal from a liability and licensing standpoint? The committee reports that in such scenarios, the focus will have to change from doing the best for each patient to maximizing the most lives saved. They recognize that such consideration will affect current patients already in the hospital for other, non-related illnesses and injuries. They also recognize that the usual scope practice standards will of necessity change, equipment and supplies will need to be rationed, documentation standards will change, and [basically, bodies will pile up.][245]

They recommend the following ethical guidelines or principles:

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[243] Health Systems Research, Inc. "Altered Standards of Care in Mass Casualty Events." AHRQ Publication No. 05-0043, April, 2005. See Attachment 3.
[244] Id. at pp. 2,3.
[245] Id. at pp.9,10

- The aim is to *keep the health care system functioning* and to deliver an "acceptable" quality of care to preserve as many lives as possible.
- The plan must be community wide.
- There must be an adequate legal framework to allow for the altered standards of care.
- The rights of individuals must be protected "to the extent possible and reasonable under the circumstances."
- The public must be informed on planning and decision making pre, during and post event.[246]

Others have addressed the question as well. An excellent treatise on the subject is found in an article by Professor Sharona Hoffman from Case Western University Law School, *q.v.* [247] Professor Hoffman believes that the term, "altered standard of care" is a misnomer since the "standard of care" is a legal term of art that is flexible. She prefers to use a different term such as "altered procedures." [248] I choose to use "altered standards of care" for the purposes of this paper.

To address legal issues there are two approaches: change state law to provide for these measures in a form such as the *Model State Emergency Powers Act*[249] or write executive orders for the Governor to sign in the event. I am proposing the latter strategy for Alabama based on Alabama's Emergency Management law, a discussion of which is found *infra.* Once again, it appears that we are drawn back into the ethical discussion between Bentham and Kant or utilitarianism versus egalitarianism.[250]

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[246] Id. at pp. 16-18.
[247] Hoffman, Sharona. *Responders' Responsibility: Liability and Immunity in Public Health Emergencies.* Case Western Reserve University School of Law, September, 2007. http://www.case.edu/ssrn.
[248] Id. at page 12.
[249] Center for Law and the Public's Health at Georgetown and Johns Hopkins Universities. http://www.publichealthlaw.net/Resources/Modellaws.htm#MSEHPA.
[250] *Q.v., supra.*

As Hoffman says, it may be argued by lawyers that the "standard of care" by definition *alters itself* in a disaster. [251] The commonly accepted "standard of care" for medical procedures is stated as "what a similarly situated provider would do in a similar circumstance."[252] If that be the case, a jury could not hold against a physician or nurse practicing in the conditions which were extant in Memorial Hospital in New Orleans in August, 2005 after the storms to those of a "sunny day" in April at one the hospitals operated by the University of Chicago or University of Alabama Birmingham or to even to the charitable Mercy Hospital. Nevertheless, providers are acutely aware that they may need some sanction for a change in the recognized standard of care. [253]

If standards of care are not "altered" and hospitals and professionals are held to the same standard they are on that "sunny day," there will be significant liability issues.

Rationing - Vaccine

Up until this point, the ethical discussion has basically been about the order of treatment for patients, but the same ethical discussion plays out on the topic of rationing of vaccine, supplies and equipment. Since we have been engaged in the discussion about the impending pandemic, CDC has issued a number of chilling statements and papers. One such is the CDC Pandemic Influenza Immunization Recommendations.[254] While the politicians and drug manufacturing companies wrangle about how to improve or revamp the decades-old system for manufacturing vaccines [255] CDC suggests what will happen if they have to deliver vaccines *now.* This report details who will get the limited supply of

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[251] See Hoffman, *supra.*

[252] See Keeton WP, Dobbs DB, Keeton RE, Owens DG: Prosser and Keeton on the Law of Torts, 5th Edition. St. Paul, West Publishing, 1984.

[253] Hoffman, at page 12.

[254] See US DHHS Pandemic Influenza Plan, November 2005. http://www.hhs.gov/pandemicflu/plan/

vaccine. And the ethical discussion comes back of placing a quantitative value on life. The CDC plan, developed in conjunction with ACIP and NVAC creates priority groups and tiers. The plan is to start with vaccinating group 1A on to 1B and so forth. Obviously, there will be overlap because CDC realizes that it is not feasible to finish a group before you move on to the next. With their plan, CDC engages the ethical discussion in an attachment. [256] CDC's priority system is as follows:

Public Health and Healthcare Personnel

- Persons directly involved with influenza vaccine and antiviral manufacturing and distribution
- Healthcare workers with direct patient contact and a proportion of persons working in essential healthcare support services.
- Public health workers with direct patient contact
- Public health emergency response workers critical to pandemic .
- Other public health workers emergency response workers

Public Safety and Essential Community Service Personnel

- Public safety personnel includes firefighters, police, dispatchers, and correctional facility staff.
- Key government leaders are those individuals needed to make policy.[257]
- Utility workers

Groups at High Risk of Influenza Complications

- Persons 65 years and older
- Persons with at least one medical condition for which influenza vaccine is recommended besides their age
- Persons 6 months - 64 years with a medical condition for which influenza vaccine is recommended
- Persons with at least two medical conditions for which influenza vaccine is recommended
- Persons hospitalized within the last year for influenza, pneumonia or other influenza high-risk condition
- Pregnant women
- Household contacts of severely immunocompromised persons (AIDS, transplant recipients, incident cancer cases)

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[255] That is its own ethical discussion for another day.

[256] See US DHHS Pandemic Influenza Plan, Part 1, Appendix D.

[257] Of course.

- Household contacts of children < 6 months
- Healthy children 6 – 23 months

A close look at the CDC system clues us that they are attempting to use a system not unlike the hybrid reasoning system outlined by Professor Tabery.[258] CDC also allows room for local input into actual utilization of the plan in a local area, however some very recent discussions coming out of Washington disclose that many local authorities *do not want* much leeway.[259] Note an earlier point that in the view of this writer, failure to make appropriate decisions "in the sunshine" causing a "disaster within a disaster" is the greatest moral failure of all.

Vaccine Rationing – A Second Look

In October of 2007, a federal interagency working group comprising members from all government sectors released the "Draft guidance on allocating and targeting pandemic influenza vaccine."[260] The document was intended to guide federal, state, tribal, and local governments, communities, and the private sector on who should be vaccinated earlier during a pandemic. While providing guidance, the plans are flexible to be able to respond effectively to the changing status of vaccine technology, the characteristics of pandemic illness, and risk groups for severe disease.

The guidance which in concept, mirrors the first iteration, identifies target groups, or people defined by a common occupation, type of service, age group, or risk level, and clusters target groups into four broad categories: homeland and national security,

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[258] See discussion Professor Tabery's lecture, *supra.*

[259] The easiest ethical course is to let someone else make the decision for you, then you can point fingers of blame in the aftermath. We experienced this in Hurricane Katrina.

[260] See http://www2a.cdc.gov/phlp/docs/prioritization.pdf.

healthcare and community support services, critical infrastructures, and the general population. Notably, children are given more consideration, though not elevated in ranking. Within individual categories, groups are clustered into levels that correspond to vaccination priority within that specific category. And, across categories, vaccine will be allocated and administered according to tiers where all groups designated for vaccination within a tier have equal priority for vaccination. Groups within tiers vary depending on pandemic severity. The guidance breaks the population down in the following manner.

> **Target Groups –** People targeted for vaccination defined by a common occupation, type of service, age group, or risk level.
> **Categories –** Pandemic vaccination target groups are clustered into four broad categories (homeland and national security, health care and community support services, critical infrastructures, and the general population). These four categories together cover the entire population.
> **Levels** – Within individual categories, groups are clustered into levels which correspond to vaccination priority within that specific category.
> **Tiers** – Across categories, vaccine will be allocated and administered according to tiers where all groups designated for vaccination within a tier have equal priority for vaccination. Groups within tiers vary on pandemic severity.[261]

Public and stakeholder input was obtained in public engagement and stakeholder meetings and from over 200 written comments submitted in response to a Request for Information issued in December 2006. Public engagement and stakeholder meetings focused on discussion of the goals and objectives of pandemic vaccination and their importance. Participants in all-day sessions heard background presentations on pandemics and pandemic vaccination, took part in small group discussions of potential vaccination program goals and objectives as well as the values underlying them, and rated each on a scale from “extremely important” to “unimportant” based on a severe pandemic scenario.

Stakeholders and the public identified the same four vaccination program objectives as most important in all of the meetings:

- Protect persons critical to the pandemic response and who provide care for persons with pandemic illness,
- Protect persons who provide essential community services,
- Protect children, and
- Protect persons who are at high risk of infection because of their occupation. [262]

According to the report, underlying the working group's deliberations was a "strong consideration of the ethical issues involved in allocating vaccine when supply is limited." Vaccinating some people earlier than others to minimize health and societal impacts of a pandemic was considered ethically appropriate. Other important principles that were considered were:

- fairness and equity (recognizing that all persons have equal value, and providing equal opportunity for vaccination among all persons in a priority group);
- reciprocity, defined as protecting persons who assume increased risk of becoming infected because of their jobs; and
- flexibility to assure that vaccine priorities are optimally tailored to the severity of the pandemic and the groups at greatest risk of severe infection and death.[263]

Rationing Equipment – Ventilators

One of the first groups to take on the ethical assignment of devising and recommending a plan for rationing equipment was American Association of Respiratory

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[261] Id. at page 4.
[262] Id. at page 16.

Care.[264] Based on their model, the Alabama Department of Public Health has put out for comment its own assignment of ventilators.[265]

The proposed Alabama “Criteria for Mechanical Ventilator Triage Following Declaration of Mass-Casualty Respiratory Emergency” [266]was adapted from the three-tier criteria developed by Drs. John L. Hicks and Daniel T. O’Laughlin.[267] ADPH suggests that hospitals utilize this criteria as a template for local and regional disaster management plans. It relies of several “triggers” including declaration of mass casualty emergency involving respiratory failure, by the Governor of Alabama or national or regional authorities, and by local HEICS commanders and activation of the National and Alabama Pandemic Flu Disaster Plans.

In Tier 1, the plan clearly calls for the withholding of ventilators [268] in certain circumstances including certain respiratory failures and evidence of certain organ failure. Then, Tier 2 would “withdraw ventilator support and not offer ventilator support” to patients with certain pre-existing organ system failures or compromises such as CHF. Tier 3 tells the staff to “withdraw ventilator support” from patients who are currently on a *ventilator but who go into a Tier 1 state.*

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[263] Id. At page 17.

[264] *Guidelines for Acquisition of Ventilators to Meet Demands for Pandemic Flu and Mass Casualty Incidents.* American Association for Respiratory Care. May 25, 2006

[265] During Hurricane Katrina, while Alabama did not face the devastation of her sister states, we did observe a shortage of ventilators on the Gulf Coast. Getting an appropriate number of ventilators for Druid City Hospital in Tuscaloosa to hospitals in need in Mobile was one of the first challenges – and successes – of Alabama’s fledgling web-based resource locating-dispatching system, AIMS. This shortage was first-hand proof that one of the first items that would be in short supply would be ventilators. The *a fortiori* argument certainly would apply in an influenza pandemic.

[266] This document is not published and is only “floating” as a draft.

[267] Id. in acknowledgment.

[268] In the Plan’s words, “do not offer ventilator support . . .”

At this point in the emergency, we begin to recall our discussion of St. Augustine's *jus ad bellum, q.v.* At the point we begin to take people *off* ventilators knowing that do so will hasten their death, we are moving perilously close to the taking of life. Didn't we read somewhere that one of "inalienable rights" is the right to *life*?

While vaccines and ventilators are the tip of the iceberg, the same ethical discussion obtains with O_2 and other medicines and supplies as well. What about when the hospital has become an island in a newly formed "sea" of floodwaters and the food and fresh drinking water are running out, will we engage the same ethical discussion?

VIII. An Ethical Guide

As alluded to earlier, the Canadians have had some major-league experience with mass infections situations, and growing out of that has been a great deal of thought, care and preparation for an impending pandemic. A very excellent report by the University of Toronto Joint Centre for Bioethics Pandemic Influenza Working Group entitled, "Stand on Guard for Thee," [269] was issued in November of 2005.[270] The report addresses a number of planning issues for a pandemic. For our purposes, I show below their breakdown of the ethical issues and their treatment of them.

> **Individual liberty** - In a public health crisis, restrictions to individual liberty may be necessary to protect the public from serious harm. Restrictions to individual liberty should:
> • be proportional, necessary, and relevant;
> • employ the least restrictive means; and
> • be applied equitably.

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[269] It can only be that the title of the report was taken from a lyric in the Canadian National Anthem, *O Canada*, which reads *in para materia*: "With glowing hearts we see thee rise/The True North strong and free!/ From far and wide/ *O Canada, we stand on guard for thee.*

[270] *Stand on Guard for Thee. Ethical considerations in preparedness planning for pandemic influenza.* University of Toronto Joint Centre for Bioethics. http://www.utoronto.ca/jcb/home /documents /pandemic.pdf

Protection of the public from harm - To protect the public from harm, health care organizations and public health authorities may be required to take actions that impinge on individual liberty. Decision makers should:
• weigh the imperative for compliance;
• provide reasons for public health measures to encourage compliance; and
• establish mechanisms to review decisions.

Proportionality - that restrictions to individual liberty and measures taken to protect the public from harm should not exceed what is necessary to address the actual level of risk to or critical needs of the community.

Privacy - Individuals have a right to privacy. In a public health crisis, it may be necessary to override this right to protect the public from serious harm.

Duty to provide [care] - Inherent to all codes of ethics for health care professionals is the duty to provide care and to respond to suffering. Ethical considerations in preparedness planning for pandemic influenza care providers will have to weigh demands of their professional roles against other competing obligations to their own health, and to family and friends. Moreover, health care workers will face significant challenges related to resource allocation, scope of practice, professional liability, and workplace conditions.

Reciprocity - requires that society support those who face a disproportionate burden in protecting the public good, and take steps to minimize burdens as much as possible. Measures to protect the public good are likely to impose a disproportionate burden on health care workers, patients, and their families.

Equity - All patients have an equal claim to receive the health care they need under normal conditions. During a pandemic, difficult decisions will need to be made about which health services to maintain and which to defer. Depending on the severity of the health crisis, this could curtail not only elective surgeries, but could also limit the provision of emergency or necessary services.

Trust - Trust is an essential component of the relationships among clinicians and patients, staff and their organizations, the public and health care providers or organizations, and among organizations within a health system. Decision makers will be confronted with the challenge of maintaining stakeholder trust while simultaneously implementing various control measures during an evolving health crisis. Trust is enhanced by upholding such process values as transparency.

Solidarity - As the world learned from SARS, a pandemic influenza outbreak, will require a new vision of global solidarity and a vision of solidarity among nations. A pandemic can challenge conventional ideas of national sovereignty, security or territoriality. It also requires solidarity within and among health care institutions. It calls for collaborative approaches that set aside traditional values of

self-interest or territoriality among health care professionals, services, or institutions.

Stewardship - Those entrusted with governance roles should be guided by the notion of stewardship. Inherent in stewardship are the notions of trust, ethical behaviour, and good decision-making. This implies that decisions regarding resources are intended to achieve the best patient health and public health outcomes given the unique circumstances of the influenza crisis.

Legal Issues

It is well beyond the scope of this paper[271] to discuss all the legal issues that a disaster presents, however it is instructive to merely point out *some* of them to further inform the ethical perspective. As we have discussed earlier [272] what is legal may not necessarily be what is ethical and what is ethical may not necessarily be what is legal. Further, this is true in three fields of legal review, criminal, civil and regulatory-administrative.

From a crimino-ethical standpoint, one may *perhaps* justify if not the volitional *taking* of life, at least the *permitting* of the taking of life by operation of "natural causes" without applying methods which *could* save the life. Tell that to the New Orleans Health-care workers now facing the possibility of indictment for everything from violation of quarantine and false imprisonment to negligent homicide and "Murder One," *aloh*a.[273]

Further, while it may be ethical to take Bentham's utilitarian approach of saving the most lives with what you have while sacrificing certain heroic measures with any particular individual, tell that to the jury in the multi-million dollar wrongful death suit

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[271] Unfortunately, that hasn't stopped the writer before. See the previous discussion of the ADA, Rehabilitation Act and Civil Rights Act.
[272] The discussion concerning public ethics laws, *q.v.*
[273] "Book 'em, Dan-O, Murder One," Steve McGarrett, *Hawaii Five-O,* CBS television, 1968-1980.

that most certainly would be brought by the "Philadelphia [274] Lawyers" hired by the family of one or more of the decedents.

Liability – There are a number of different forms of liability both personal and corporate, a discussion of each is beyond the scope of this paper, but possibilities include:

Individual Liability

- Malpractice and professional liability
- Invasion of privacy, confidentiality breach
- General tort liability – negligence or an act or omission
- Economic loss
- Non-economic loss
- Gross negligence, wanton misconduct, bad faith

Corporate or Group Liability

- Corporate Negligence
- Vicarious liability/Respondeat superior
- Negligent recruitment/training/supervision
- Premises liability

Still further, tell it to the Centers for Medicare and Medicaid Services (CMS,) the Inspector General of the United States Department of Health and Human Services (IG/HHS,) the Department of Justice, Medicare and Medicaid Fraud and Abuse Division (DOJ) and any other combination of alphabet-soup regulatory agencies at the federal and state level when they either refuse to pay you or threaten to investigate you for fraud (not to mention HIPAA violations galore.)

Affected federal laws can include: Civil Rights Act of 1964, Americans with Disabilities Act, Rehabilitation Act of 1973, Section 504, [275] EMTALA, HIPAA, Pure Food, Drug and Cosmetic Acts (medicines and medial devices,) the "Common Rule" involving research with human subjects, Wage and Hour (FLSA), "80 hour a week rule

[274] Philadelphia, PA, not Philadelphia, MS.
[275] See previous discussion.

for medical residents” rule, OSHA, CMS reimbursement under Medicare and Medicaid and the Stafford Act – to name a few. The Secretary of HHS issued waivers for a number of federal acts and rules in Hurricane Katrina.[276]

Involved state laws would include: mass vaccination requirement issues, property seizure and “takings” issues, various health care facility and individual practitioner licensure laws, and building codes among others.

Fixing the Problem - There would be a variety of methods that could be used to address these issues that involve everything for how facilities write their contracts and MOUs to the issuance of Presidential Decision Directives (PDDs) under the terrorist laws and all stops in between. These would require the political will to do it. Perhaps an attempt by federal authorities to implement such change would be a statement of their belief in the need to engage in this exercise and their commitment to the planning process.

Certain Social Security Act waivers can be issued by the Secretary of HHS, *see supra.* Laws can be enacted to grant specific protections to individuals and entities dealing with the situation such as were written for the smallpox vaccinations of the early 2000s. [277] Existing laws can be changed *per se* at the federal and state levels [278] or can be changed to allow for regulations to be changed in conjunction with the pre-writing of executive orders to be issued by the Governor allowing changes to be made under the Governor’s authority issue such order in states of emergency, which authority is found in

[276] *Waivers Under Section 1135 of the Social Security Act*, http://www.hhs.gov/Katrina/ssawaiver.html>
[277] See the Section 304 of the Homeland Security Act of 2002, 42 USC § 233(p).
[278] Definitional sections of the ADA, Rehabilitation Act and Civil Rights Act could specifically give exclusions.

most states' laws.[279] Each and every one of these decisions will, of necessity, have to be thrashed out in the area of private and public comment among affected parties – and at this point, who isn't "affected?"

In making those decisions in advance, there will have to be significant comparison of not only ethical principles but also of competing interests of persons and groups of person and of individuals *representing* persons and groups of persons.

Health Care Workers' Right to Desertion, *vel non*

The writer began this paper with the ethical situation faced by health care workers in New Orleans and along the Gulf Coast.[280] In the paper written by nurses,[281] some of whom lived through the storm, we found that many left town after the storm perhaps never to return. We all remember the stories of other non-health workers leaving town as well – but before or during the storm. Fifty-one New Orleans police officers and employees were fired for desertion of duty before or during the storm. MSNBC News, quoting acting police superintendent Warren Riley said. "They either left before the hurricane or 10 to 12 days after the storm, and we have never heard from them." The report goes on to state that police were "unable to account for 240 officers on the 1,450-member force following Katrina." [282]

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[279] To be compatible with national requirements for emergency funding under the Robert T. Stafford Act Disaster Assistance Act, 42 U.S.C. § 5121 *et seq.,* establishing the rights of states to enter into interstate mutual assistance compacts and NIMS require states to have adopted legislation which, *inter alia* gives the Governor the authority to make or change state law. Alabama's act is attached as Attachment 2.
[280] See page 4.
[281] Yolanda M. Powell-Young, Dillard University Division of Nursing; Janelle R. Baker, Florida A & M University School of Nursing, and Jacqueline G. Hogan, Touro Infirmary, New Orleans, Louisiana . "Disaster Ethics, Health care and Nursing: A Model Case Study to Facilitate the Decision Making Process."
[282] www.msnbc.msn.com. Oct 31, 2005.

However, some have argued that the New Orleans desertions were an anomaly. Professor William L. Waugh, Jr. of Georgia State University, writing the Annals of the American Academy of Political Sciences, finds a number of exacerbating factors peculiar to New Orleans that might not re-occur. He states:

> The poor emergency response was in many respects due to the sheer scale of the disaster. Roads were impassable, bridges were destroyed, and victims were scattered among hundreds of communities. Water, downed lines, debris, and reports of violence delayed rescue and relief. The unexpectedly large number of people needing assistance during and immediately after the levee breaches revealed a clear divide between those who had the resources to evacuate and the very large poor population lacking resources to evacuate or even to survive until help could arrive. It should always be expected that a significant percentage of the population will not evacuate for a variety of reasons and that they will not have prepared for surviving for days without food or water-many can only afford to live day to day in their normal lives. Local, state, and federal governments were confused about who would take the lead even though lead responsibility rested with state officials.[283]

Jane Kushman of the Institute for Emergency Preparedness of Jacksonville State University, writing in the Natural Hazards Observer, states that desertion by emergency workers, what she terms "role abandonment," has been discussed in the disaster literature since the 1950s. She notes that several early studies confirmed that emergency workers suffered psychological strain due to the conflicting demands of their professional duties and their desire to take care of their families. However, she emphasizes that these studies also reported that role conflict and strain did not lead emergency workers to abandoning their professional responsibilities. [284]

Kushman goes on to mention a 1976 Dynes and Quarantelli study of more than 100 disasters with interviews exceeding 2,500 with organizational officials. This study

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[283] Waugh, William L. Jr., *The Political Costs of Failure in the Katrina and Rita Disasters,* 604 Annals of the American Academy of Political Science 288 (March, 2006.)

concludes that role conflict was not a serious problem that created a significant loss of manpower. She states:

> With the exception of Hurricane Katrina and the New Orleans Police Department, there have been no documented reports of widespread role abandonment during disasters in the United States. Nevertheless, belief in this myth by the public and even government officials continues and has been reinforced through popular culture and erroneous reporting by the mass media. [285]

The Powell-Young nurse's report finds their nurses claiming the same ethical dilemma faced by health care – and other – workers in such a magnitudinal disaster when "the event requires commitment to a single obligation when two or more genuine duties exist."[286] In other words, the nurses and other health care providers had to make hierarchical quantification of value principles at work as well as at home. Assuming that these nurses (and policemen for that matter) are in the 20 percent [287] of all nurses who will consistently attempt to act in an ethical manner, what was their higher obligation, to save their patients or save their families? If they choose to stay and work, is their higher obligation to save as many patients as possible or to render the best care they can to each and every patient. Again, we are thrust back into Kant and Bentham's principlism versus utilitarianism debate. Even if one attempts to maintain a principlist approach, the values compete.

The Powell-Young Report [288] offers a breakdown of some of the competing value principles:

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[284] Kushman, Jane, *Role Abandonment in Disaster: Should we leave this myth behind?*, The University of Colorado at Boulder *National Hazards Observer*, Vol. 31, No. 5, May, 2007

[285] Id.

[286] Powell-Young , page 3.

[287] See the discussion of the "Pareto Principle" at page 4.

[288] Powell-Young, page 4.

- *Autonomy v. Non-maleficence* - mandatory evacuation with spouse vs. duty to employer despite risks.
- *Autonomy v. Beneficence* - Evacuation of self and ill spouse post-Katrina vs. mandatory lock-in
- *Autonomy v. Justice* - Evacuation of self and ill spouse post-Katrina vs. employer contract for provision of spouse's medical needs.

And there would be other conflicts as well. In the global pandemic additional questions of desertion would surface: the duty to work for an institution uniquely designed to combat the influenza pandemic versus the duty to protect their own lives as well as the lives of their loved ones.

Even the Kushman report finds otherwise willing workers to be less likely to report for duty if the event in question were a pandemic influenza outbreak. She reports the results of a study by Balicer et al. in 2005 that surveyed local public health workers. The Balicer study found that nearly *half* the respondents stated they would not report for duty during an influenza pandemic, with a greater likelihood of reporting for clinical workers than technical and support staff. [289]

Lastly, Kushman cites a 2005 study by Qureshi et al. of more than 6,000 workers from 47 health care facilities in the New York City metropolitan region about their "ability" and "willingness" to report to work during various catastrophic events. Health care workers said they were most willing to report to work during mass casualty incidents (86%) and were least willing to report during a SARS outbreak (48%) or smallpox epidemic (61%). Fear and concern for family and self and personal health problems were

[289] Kushman, *supra.*

the most frequently cited barriers to "willingness." These findings certainly have implications for planning and preparedness efforts.[290]

Professor Tabery [291] argues that the workers must find a way personally to *balance* these competing obligations. We have already seen the AMA and ANA statements that basically say the same thing – balance must be found. Further, codes such as AMA's and ANA's apply to only those healthcare workers who have these specific jobs and belong to the respective organizations. They don't even attempt to address support staff. How can you run a hospital without support staff?

While the facilities themselves have a great deal of ethical responsibility to prepare for such eventualities, much of which requires "thinking outside the box" of current hospital management practice and extends past the workers to their families, it is incumbent on workers to come to the realization, as we have said early in this paper that they chose this profession, not unlike a marriage – for better or worse and in so doing, they have, in effect, made certain decisions already.

Professor Tabery [292] reminds the health care worker:

> If you don't come to work, the problem doesn't go away. In fact, the problem only gets worse. In a disaster situation or a pandemic, every employee will make a difference by contributing his or her part to providing care. All employees must ask themselves, 'If I don't work in times of crisis, then who will?'

It is interesting to note that though workers' agreement to report for duty to some degree depends on the type of emergency, other factors may also be involved. In a survey, ninety percent of health care workers reported at least one barrier to their

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[290] Id.
[291] Professor James Tabery, cited *supra.*
[292] Id.

willingness to report in an event, including similar issues regarding family responsibilities, such as child, elder and pet care. The author of the study points out that "many of the barriers identified are amenable to intervention. For example, pre-disaster plans can be developed for the transportation of medical staff, and adjustment of staff schedules can be arranged so that staff can share among themselves child, elder, or pet care responsibilities."[293]

This in no way removes the duty from the worker to report, but it does thrust a moral imperative upon health care facilities and public health entities to create mechanisms to overcome barriers to worker's fears of participating in an event in much the same manner in which Toronto created new ways to offer "carrots" to citizens to obey quarantine orders in the SARS outbreak.[294]

Facilities and public health entities have a duty to realize that workers come to them not as we wish they were but in the words of the old hymn, *Just as I Am.* [295] Wishing it wasn't so won't get any more patients treated, but meeting workers, "just as they are" will. In this vein, there is shared duty among public health entities, health care facilities, professional organizations and health care workers themselves to take all necessary means to insure that staff will actually report and continue to report when faced with a disaster. [296]

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[293] David Vlahov, PhD , ed., *Health Care Workers' Response to Catastrophic Disasters*. The Journal of Urban Health, a quarterly publication of The New York Academy of Medicine. September 7, 2005, citing studies by Qureshi and Gershon in New York City.

[294] See *Stand on Guard for Thee* at note 209

[295] *Just as I Am without One Plea,* words by Charlotte Elliott, 1835, music by William Bradbury, 1849.

[296] The Alabama Department of Public Health has placed, "responds to disasters" in the job descriptions of *all* its employees. Employees understand upon hiring that they may be called upon to leave their "day job." And be dispatched to the site of a disaster. Likewise, the Police Department of the City of Tuscaloosa, Alabama meets with the *families* of all new officers to reinforce to them that in the face of a local disaster, the officer's first duty is to the people of Tuscaloosa. The families are expected to understand

Public health would say that pandemic influenza planning, in this case as related to facility staff situations, comes down to two essential components, personal preparedness [297] and continuity of operations planning (COOP). Public health organizations have a duty to assist facilities in the planning process[298] and to educate facility administrators, staff and the public in general what some of those measures might be. [299]

Personal preparedness is not only a personal priority for the worker but also for the facility that employs workers. If employees are not prepared at home they will not come to work. In that case, all the organizational planning for COOP would be wasted. Public health has suggested that to ensure that employees are personally prepared, education and discussions must include family plans (child care, parents, and pets), stockpile (food, water, and over the counter medications), and medical care (prescriptions and home care).

Those factors that cause worker desertions can be identified and indeed the major ones have already been so identified. It will be ethically necessary for facility planners to take novel measures to "eliminate the excuses." According to the WHO, [300] the role and duty of pandemic planners should include the following bullets. Perhaps equally as important, facility planners should make sure those workers, in advance, know that these

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[297] See <http://www.pandemicflu.gov/plan/tab3.html>

[298] Department of Health and Human Services, Office of the Assistant Secretary for Preparedness and Response (ASPR) fiscal 2008.

[299] *Code of Ala. 1975*, §22-2-2 places on public health the general obligation to educate the public on matters of public health.

[300] "The Role and Obligations Of Health-Care Workers During An Outbreak Of Pandemic Influenza," World Health Organization Working Paper, Dr Ross Upshur, University of Toronto, Chairman. September 14, 2006.

things *will be taken care of*. That – is what alleviates much of the fear and removes some of the excuses for desertion.

- Ensure that the right of health care workers to safe working conditions;
- Ensure that health care workers will receive sufficient support throughout a period of extraordinary demands;
- Plan for education and training of all workers on hygienic measures (such as hand hygiene) that reduce risk to health care workers and recipients of care;
- Take steps to enhance and enable the voluntary participation of health care workers in a pandemic response;
- Ensure the participation in planning of formal and informal care networks, engaging clinical and non-clinical, professional and non-professional health care workers;
- Recognize the role of gender and culture (including religion) in the provision of health care and its relevance to an effective pandemic response;
- Develop human resource strategies that cover the diverse occupational roles, that are transparent in how individuals are assigned to roles in the management of the pandemic, and that are equitable with respect to the distribution of risk among individuals and occupational categories; and
- Ensure that processes be in place to accommodate legitimate exceptions to the provision of clinical care (e.g. pregnancy, immunodeficiency, family member affected.)

As we said, the duty is shared. Again, according to WHO [301] the role and duty of professional and non-professional health care workers during a pandemic includes a recognition by the worker, as taught by the facility, public health and professional organizations that the participation of health care providers is essential to an effective response to pandemic influenza and that health care workers have unique skills that confer an obligation to respond. Workers should also be taught that the level of acceptable risk a health care worker is willing to countenance is a matter of personal choice. However, it is incumbent on the facility to provide a process for workers to come to grips with what this level is in his or her life consistent with John's Five Action Principles, *q.v.*

WHO [302] reminds professional associations that they have a duty to:

- Provide, by way of their codes of ethics, clear guidance to members in advance of an influenza pandemic. Some have been more successful at this than others.
- Identify mechanisms, or develop means to inform members as to expectations and obligations regarding the duty to provide care during a communicable disease outbreak and during an influenza pandemic.

The WHO report lastly outlines measures for governments to take. Of interest is the WHO's admonition against using legal pressure on workers, observing that sanctions for failure to report should only be resorted to against health care workers who fail to respond within the context of the existing rules of professional associations and contract law (e.g., reprimand or loss of license, dismissal from employment.) WHO warns that sanctions should not contravene human rights of the worker or the worker's family in any

[301] Id.

way. Governments, says WHO, wishing to take steps to ensure a response from the health care sector are urged to employ voluntary measures.

I submit that those voluntary measures are assistance in planning, coordination of systems and public education. Perhaps, though the most important function of government and governmental public health agencies is to bring about John's last Action Principle – *The Nike Principle* – Just Do It! Public health has the ethical duty to make this happen, if we fail that, people will die and we will have to live with that failure the rest of our careers and lives. My observation over thirty some-odd years in public health is that when presented with a task, public health has always and always will rise to the task. We will remember the spirit of the ancients that is still among us and guided by that spirit will not fail nor falter.

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[302] Id.

IX. Exercise: *The Kobayashi Maru*[303]

In the *Star Trek* fictional universe, the ***Kobayashi Maru*** is a starship that serves as the subject of a graded training exercise at Starfleet Academy, in which command division cadets are presented with a no-win scenario as a test of character. It was first depicted in the opening scene of the film *Star Trek II: The Wrath of Khan*, in which it provided context for how the main character, Admiral James T. Kirk, deals with the possibility of unwinnable situations, and death in particular. The term *Kobayashi Maru* was referenced in subsequent *Star Trek* works as a shorthand for no-win scenarios, and also became popular among fans.

In The training exercise in *Star Trek II* describes the *Kobayashi Maru* as a third-class neutronic fuel carrier-ship, with a crew of 81 and about 300 passengers. The name is Japanese, and loosely translates as *the ship named Kobayashi*, with *Kobayashi* (meaning *small forest* and being a common family name. *Maru* means *perfection* or *purity* and is a common suffix for Japanese ship names, implying a safe return always, or "round journey".

Scenario: In the year 2030, the Kobayashi Maru is a large interplanetary ship taking the first colony to Mars. As it approaches Mars, it is hit by Asteroid 1997 XF11 on the backside of its 2028 Earth Close-approach. (about 4 x the distance to the moon.) In its crippled state, the ship is “dead in the water.” Help from Earth may or may not come and may or may not come in time to save the ship.

Population: There are 81 crew members including Captain Christopher Pike. The 300 passengers, who are to be the founders of the colony reflect the make up of the United States based on the 2000 census (most recent available data.) It includes a cross section of handpicked society: civil leaders, scientists, and teachers, even students. See sample breakdown, *supra.*

Study questions:

1. **Given the scare resources, who gets what resources?**
2. **Who decides who gets what resources?**
3. **What is your rationale for your decision?**

[303] Michael Okuda, Denise Okuda and Debbie Mirek, *The Star Trek Encyclopedia – A Reference Guide to the Future*. New York, 1994.

Make up of the population – Source: 2000 US Census

Civilian labor force	**64.1**	
Agriculture	**2.51**	Out of total employed population
Non-agricultural industry	**97.49**	Out of employed population
Ratios per occupation	-	Out of total labor force
Managerial and professional specialty	30.61	
Technical, sales & administrative support	28.8	
Service occupations	13.34	
Precision production, craft and repairs	10.88	
Operators, laborers and fabricators	13.86	
Farming	2.51	
Per activity (excluding agriculture)	-	
Industry	**97.49**	
Goods manufacturing	**19.32**	Out of which:
Mining	0.41	Provided by the lunar extraction facility
Construction	5.01	
Manufacturing	13.9	
Durable goods	8.31	
Non-durable goods	5.59	
Food industry	23.1	Out of non-durable goods industry employment
Food industry	1.29	Out of total employed population
Recycling industry	**3**	

Services (1) - producing	**75.17**	
Transportation	3.35	
Communications & public utilities	1.81	
Wholesale trades	5.21	
Retail trades	17.14	
Finance & insurance	5.86	
Services (2)	**26.51**	part of the services employed population (1)
Health services	4	
Engineering services	7	Including space engineering,
Recreation services	1.2	Including parks' and theatres' management and maintenance,
Business services	6.8	
Computer and data processing services	45	Percentage out of the business services' employed population
Social services	2	Residential care, child care etc.
Settlement maintenance services	3	
Security services	0.5	
Tourism	1.51	Hotel personnel, guides and so on; necessary for development of space tourism
Miscellaneous	0.5	
Government services	**15.29**	
Education services	12.5	
Other government services	2.79	Including defense and Meteor collision prevention system

X. Epilogue

"The secret's in the sauce,"[304] says Sipsey to Curtis Smoot, the Georgia Sheriff, about why the bar-be-cue was so good that day at the Whistlestop Café in rural East Alabama. Like that sauce, there was a secret hidden away in this paper. Hopefully, you discovered it. (*Hint*:) The planning principles espoused herein apply not only to disaster planning but also to life as well – your life. If you apply these principles to the way you live your life, as Justin Wilson [305] would say, "I ga-ron-tee" (*sic)* that no matter what hurricanes, tornadoes, tragedies or pandemics hit you personally, your life will never be a *disaster*. You will never be a sparrow fluttering helplessly in the wind; you will soar like the Eagle.

The Eagle Soars

The Eagle soars above the din,
Of mankind's rushing out and in,
And lesser creatures left to spin,
The Eagle soars from deep within.

His course is true as gaffer's pike,
His keen eye pierces like a spike,
His quest surrounds him like a dike,
The Eagle soars, but phantomlike.

Those who on the Earth have stood,
Thinking that they never could,
Nor many even perhaps should ... but,

The Eagle soars because he *would*.[306]

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[304] "The secret's in the sauce," from *Fried Green Tomatoes at the Whistlestop Cafe*, (1987) by the Alabama writer and actress, Fannie Flagg.

[305] Justin E. Wilson (April 24, 1914 - September 5, 2001,) was a southern American chef, humorist and self-styled "raconteur" known for his brand of Cajun cuisine-inspired cooking and humor.

[306] John R. Wible, 1981.

Attachment No. 1

Ethical Considerations in the Event of an Influenza Pandemic: Selected Readings

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Attachment No. 2
Powers and Duties of Alabama's Governor in Emergencies

Section 31-9-6, *Code of Alabama, 1975.*
Powers and duties of Governor with respect to emergency management generally. In performing his duties under this chapter, the Governor is authorized and empowered:

(1) To make, amend and rescind the necessary orders, rules and regulations to carry out the provisions of this chapter within the limits of the authority conferred upon him in this chapter, with due consideration of the plans of the federal government.

(2) To prepare a comprehensive plan and program for the emergency management of this state, such plan and program to be integrated and coordinated with the emergency management plans of the federal government and of other states to the fullest possible extent, and to coordinate the preparation of plans and programs for emergency management by the political subdivisions of this state, such plans to be integrated into and coordinated with the emergency management plans and programs of this state to the fullest possible extent.

(3) In accordance with such plan and program for the emergency management of this state, to ascertain the requirements of the state, or the political subdivisions thereof, for food or clothing or other necessities of life in the event of disaster or emergency and to plan for and procure supplies, medicines, materials and equipment for the purposes set forth in this chapter; to make surveys of the industries, resources and facilities within the state as are necessary to carry out the purposes of this chapter; to institute training programs and public information programs; and to take all other preparatory steps, including the partial or full mobilization of emergency management organizations in advance of actual disaster, to insure the furnishing of adequately trained and equipped forces of emergency management personnel in time of need.

(4) To make, amend and rescind the necessary orders, rules and regulations looking to the direction or control of practice blackouts, air raid drills, mobilization of emergency management forces and other tests and exercises, warnings and signals for drills or attacks, the mechanical devices to be used in connection therewith, the effective screening or extinguishing of all lights and lighting devices and appliances, the conduct of civilians and the movement or cessation of movement of pedestrians and vehicular traffic, public meetings or gatherings, the evacuation and reception of civilian population, and shutting off water mains, gas mains, electric power connections and the suspension of all other public utilities, during, prior and subsequent to drills or attacks.

(5) To create and establish mobile support units and to provide for their compensation.

(6) To cooperate with the President and the heads of the armed forces, with the Emergency Management Agency of the United States and with the officers and agencies

of other states in matters pertaining to the emergency management of the state and nation and the incidents thereof.

(7) With due consideration to the recommendation of the local authorities, to appoint full-time state and regional area directors.

(8) To utilize the services and facilities of existing officers and agencies of the state and the political subdivisions thereof.

(9) On behalf of this state, to enter into reciprocal aid agreements or compacts with other states and the federal government. Such mutual aid agreements shall be limited to the furnishing or exchange of food, clothing, medicine and other supplies; engineering services; emergency housing; police services; national or state guards while under the control of the state; health, medical and related services; fire fighting, rescue, transportation and construction services and equipment; personnel necessary to provide or conduct these services; such other supplies, equipment, facilities, personnel and services as may be needed; and the reimbursement of costs and expenses for equipment, supplies, personnel and similar items for mobile support units, fire fighting and police units and health units. Such agreements shall be on such terms and conditions as are deemed necessary.

(10) To sponsor and develop mutual aid plans and agreements between the political subdivisions of the state, similar to the mutual aid agreements with other states referred to in subdivision (1) of this section.

(11) To delegate any administrative authority vested in him under this chapter, and to provide for the subdelegation of any such authority.

(12) To take such action and give such directions to state and local law-enforcement officers and agencies as may be reasonable and necessary for the purpose of securing compliance with the provisions of this chapter and with the orders, rules, and regulations made pursuant thereto.

ATTACHMENT 3

Altered Standards of Care in Mass Casualty Events Agency for Healthcare Research and Quality U.S. Department of Health and Human Services Health Systems Research, Inc. AHRQ Publication No. 05-0043 April 2005 - Excerpt

Substantial work has already been done and continues to be undertaken throughout the country to improve the ability of health systems to respond to acts of terrorism or other public health emergencies. Much of the planning in this area focuses on increasing the surge capacity of affected delivery systems through the rapid mobilization and deployment of additional resources from the community, State, regional, or national levels to the affected area. However, few of these plans specifically address a situation in which the delivery system is unable to respond (even if only temporarily) according to established standards of care due to the scope and magnitude of a mass casualty event.

A key issue upon which the experts agreed is that the goal of the health and medical response to a mass casualty event is to save as many lives as possible. There is consensus that, to achieve this goal, health and medical care will have to be delivered in a manner that differs from the standards of care that apply under normal circumstances. This issue is not addressed in a comprehensive manner in many preparedness plans. Finally, the experts also agreed that for health and medical care delivered under these altered standards to be as effective as possible in saving lives, it is critically important that current preparedness planning be expanded to explicitly address this issue and to provide guidance, education, and training concerning these altered care standards. Standards of health and medical care, broadly defined, address not only what care is given, but to whom, when, by whom, and under what circumstances or in what places.

A comprehensive set of standards for health and medical care specifies the following:

- What—what types of interventions, clinical protocols, standing orders, and other specifications should be used in providing health and medical care?
- To whom—which individuals should receive health and medical care according to their condition or likelihood of response?
- When—with what urgency should health and medical care be provided?
- By whom—which individuals are certified and/or licensed to provide care within a defined scope of practice and other regulations?
- Where—what facility and system standards (pre-hospital, hospital, alternate care site, etc.) should be in place for the provision of health and medical care

Under normal conditions, current standards of care might be interpreted as calling for the allocation of all appropriate health and medical resources to improve the health status and/or save the life of each individual patient. However, should a mass casualty event occur, the demand for care provided in accordance with current standards would exceed system resources. In a small rural hospital, 10 victims from a local manufacturing accident might be considered a mass casualty event.

In a metropolitan area, several hundred victims would be manageable within system resources. In an event involving thousands of victims, preserving a functioning health care system will require a move to altered standards of care. It may also be necessary to create both pre-hospital operations and alternate care sites to supplement hospital care.

The term “altered standards” has not been defined, but generally is assumed to mean a shift to providing care and allocating scarce equipment, supplies, and personnel in a way that saves the largest number of lives in contrast to the traditional focus on saving individuals. For example, it could mean applying principles of field triage to determine who gets what kind of care. It could mean changing infection control standards to permit group isolation rather than single person isolation units. It could mean limiting the use of ventilators to surgical situations. It could mean creating alternate care sites from facilities never designed to provide medical care, such as schools, churches, or hotels. It could also mean changing who provides various kinds of care or changing privacy and confidentially protections temporarily.

Altered standards could include: Triage efforts that will need to focus on maximizing the number of lives saved. Instead of treating the sickest or the most injured first, triage would focus on identifying and reserving immediate treatment for individuals who have a critical need for treatment and are likely to survive. The goal would be to allocate resources in order to maximize the number of lives saved. Complicating conditions, such as underlying chronic disease, may have an impact on an individual’s ability to survive.

Triage decisions that will affect the allocation of all available resources across the spectrum of care: from the scene to hospitals to alternate care sites. For example, emergency department access may be reserved for immediate-need patients; ambulatory patients may be diverted to alternate care sites (including nonmedical space, such as cafeterias within hospitals, or other nonmedical facilities) where "lower level" hospital ward care or quarantine can be provided. Intensive or critical care units may become surgical suites and regular medical care wards may become isolation or other specialized response units. Needs of current patients, such as those recovering from surgery or in critical or intensive care units; the resources they use will become part of overall resource allocation. Elective procedures may have to be cancelled, and current inpatients may have to be discharged early or transferred to another setting. In addition, certain lifesaving efforts may have to be discontinued.

Usual scope of practice standards that will not apply. Nurses may function as physicians, and physicians may function outside their specialties. Credentialing of providers may be granted on an emergency or temporary basis. Equipment and supplies that will be rationed and used in ways consistent with achieving the ultimate goal of saving the most lives (e.g., disposable supplies may be reused). Not enough trained staff. Staff will be scared to leave home and/or may find it difficult to travel to work. Burnout from stress and long hours will occur, and replacement staff will be needed. Some scarce and valuable equipment, such as ventilators, may not be used without staff available who are trained to operate them. Delays in hospital care due to backlogs of patients. Patients will be waiting for scarce resources, such as operating rooms, radiological suites, and laboratories.

Providers that may need to make treatment decisions based on clinical judgment. For example, if laboratory resources for testing or radiology resources for x-rays are exhausted, treatment based on physical exam, history, and clinical judgment will occur.

The psychological impact of the event on providers. Short- and long-term stress management measures (e.g., Critical Incident Stress Management programs) are essential for providers and their families. Current documentation standards that will be impossible to maintain.

Providers may not have time to obtain informed consent or have access to the usual support systems to fully document the care provided, especially if the health care setting is damaged by the event.

Backlog in processing fatalities. It may not be possible to accommodate cultural sensitivities and attitudes toward death and handling bodies. Numbers of fatalities may make it difficult to find and notify next of kin quickly. Burial and cremation services may be overwhelmed. Standards for completeness and timeliness of death certificates may need to be lifted temporarily.

Based on a review of the health and medical care issues…, the panel of experts identified a need for more guidelines to ensure a systematic approach to decision making in mass casualty events. Guidelines should take into account and be scaleable to the size, nature, and speed of the event, so that they can guide the following decisions:

- How to ensure and protect an adequate supply of trained providers and support staff How to triage patients into groups by the nature of their condition, probability of success of interventions/treatment, and consideration of resources available.
- How to maintain infection control and a safe care environment.
- How to use and reuse common supplies and equipment, such as gloves, gowns, and masks.
- How to allocate scarce clinical resources of a general nature, such as beds, surgery capability, and laboratory and other diagnostic services.
- How to allocate scarce and highly specialized clinical resources, such as decontamination units, isolation units, ventilators, burn beds, and intensive and critical care units.
- How to treat specific conditions, including how to make best use of available pharmaceuticals.
- How to protect health care providers and support staff and their families.
- How to modify documentation standards to ensure enough information to support care and obtain reimbursement without posing an undue administrative burden
- How to manage excessive fatalities The panel of experts was quite clear in its view that if the health care system is to be successful in saving as many lives as possible, planning, education, and training efforts should be focused on the development and implementation of appropriate altered standards of care in response to a mass casualty event.

ATTACHMENT 4

680-X- 2-.22 Code of Professional Conduct. [Alabama Board of Pharmacy]

(1) Pharmacists are expected to conduct themselves in a professional manner at all times. The following code provides principles of professional conduct for pharmacists to guide them in their relationship with patients, fellow practitioners, other health professionals and the public.

(2) Violations of any provisions of this rule shall be deemed grounds for disciplinary action whenever the Board shall find a preponderance of evidence to such violations.

(a) A pharmacist should hold the health and safety of patients to be of first consideration and should render to each patient the full measure of professional ability as an essential health practitioner.

(b) A pharmacist should never knowingly condone the dispensing, promoting, or distributing of drugs or medical devices, or assist therein, that are not of good quality, that do not meet standards required by law, or that lack therapeutic value for the patient.

(c) A pharmacist should always strive to perfect and enlarge professional knowledge. A pharmacist should utilize and make available this knowledge as may be required in accordance with the best professional judgment.

(d) A pharmacist has the duty to observe the law, to uphold the dignity and honor of the profession, and to accept its ethical principles. A pharmacist should not engage in any activity that will bring discredit to the profession and should expose, without fear or favor, illegal or unethical conduct in the profession. Chapter 680X2 Pharmacy Board Supp. 3/31/08 240

(e) A pharmacist should respect the confidential and personal nature of professional records; except where the best interest of the patient requires or the law demands, a pharmacist should not disclose such information to anyone without proper patient authorization.

(f) A pharmacist should not agree to practice under terms or conditions that interfere with or impair the proper exercise of professional judgment and skill, that cause a deterioration of the quality of professional services, or that require consent to unethical conduct.

(g) A pharmacist should strive to provide information to patients regarding professional services truthfully, accurately, and fully and should avoid misleading patients regarding the nature, cost or value of these professional services. Author: James W. McLane Statutory Authority: Code of Ala. 1975, §342392. History: Filed May 30, 1990. Editor's Note: the Joint Committee on Administrative Regulation Review disapproved This rule on July 17, 1990. The full Legislature failed to sustain the suspension by the Joint Committee, (HJR 43), at the 1991 Regular Session. (See Code of Ala. 1975, §§412223, 412224.)

ATTACHMENT 5.
Code of Ethics American Pharmacists Association

I. A pharmacist respects the covenantal relationship between the patient and pharmacist. Considering the patient-pharmacist relationship as a covenant means that a pharmacist has moral obligations in response to the gift of trust received from society. In return for this gift, a pharmacist promises to help individuals achieve optimum benefit from their medications, to be committed to their welfare, and to maintain their trust.

II. A pharmacist promotes the good of every patient in a caring, compassionate, and confidential manner. A pharmacist places concern for the well being of the patient at the center of professional practice. In doing so, a pharmacist considers needs stated by the patient as well as those defined by health science. A pharmacist is dedicated to protecting the dignity of the patient. With a caring attitude and a compassionate spirit, a pharmacist focuses on serving the patient in a private and confidential manner.

III. A pharmacist respects the autonomy and dignity of each patient.

A pharmacist promotes the right of self-determination and recognizes individual self-worth by encouraging patients to participate in decisions about their health. A pharmacist communicates with patients in terms that are understandable. In all cases, a pharmacist respects personal and cultural differences among patients.

IV. A pharmacist acts with honesty and integrity in professional relationships.

A pharmacist has a duty to tell the truth and to act with conviction of conscience. A pharmacist avoids discriminatory practices, behavior or work conditions that impair professional judgment, and actions that compromise dedication to the best interests of patients.

V. A pharmacist maintains professional competence. A pharmacist has a duty to maintain knowledge and abilities as new medications, devices, and technologies become available and as health information advances.

VI. A pharmacist respects the values and abilities of colleagues and other health professionals. When appropriate, a pharmacist asks for the consultation of colleagues or other health professionals or refers the patient. A pharmacist acknowledges that colleagues and other health professionals may differ in the beliefs and values they apply to the care of the patient.

VII. A pharmacist serves individual, community, and societal needs. The primary obligation of a pharmacist is to individual patients. However, the obligations of a pharmacist may at times extend beyond the individual to the community and society. In these situations, the pharmacist recognizes the responsibilities that accompany these obligations and acts accordingly.

VIII. A pharmacist seeks justice in the distribution of health resources. When health resources are allocated, a pharmacist is fair and equitable, balancing the needs of patients and society.

ATTACHMENT 6 - EMT CODE OF ETHICS

Professional status as an Emergency Medical Technician and Emergency Medical Technician-Paramedic is maintained and enriched by the willingness of the individual practitioner to accept and fulfill obligations to society, other medical professionals, and the profession of Emergency Medical Technician. As an Emergency Medical Technician-Paramedic, I solemnly pledge myself to the following code of professional ethics:

> A fundamental responsibility of the Emergency Medical Technician is to conserve life, to alleviate suffering, to promote health, to do no harm, and to encourage the quality and equal availability of emergency medical care.
>
> The Emergency Medical Technician provides services based on human need, with respect for human dignity, unrestricted by consideration of nationality, race creed, color, or status.
>
> The Emergency Medical Technician does not use professional knowledge and skills in any enterprise detrimental to the public well being.
>
> The Emergency Medical Technician respects and holds in confidence all information of a confidential nature obtained in the course of professional work unless required by law to divulge such information.
>
> The Emergency Medical Technician, as a citizen, understands and upholds the law and performs the duties of citizenship; as a professional, the Emergency Medical Technician has the never-ending responsibilty to work with concerned citizens and other health care professionals in promoting a high standard of emergency medical care to all people.
>
> The Emergency Medical Technician shall maintain professional competence and demonstrate concern for the competence of other members of the Emergency Medical Services health care team.
>
> An Emergency Medical Technician assumes responsibility in defining and upholding standards of professional practice and education.
>
> The Emergency Medical Technician assumes responsibility for individual professional actions and judgment, both in dependent and independent emergency functions, and knows and upholds the laws, which affect the practice of the Emergency Medical Technician.
>
> An Emergency Medical Technician has the responsibility to be aware of and participate in matters of legislation affecting the Emergency Medical Service System.
>
> The Emergency Medical Technician, or groups of Emergency Medical Technicians, who advertise professional service, do so in conformity with the dignity of the profession.

The Emergency Medical Technician has an obligation to protect the public by not delegating to a person less qualified, any service which requires the professional competence of an Emergency Medical Technician

The Emergency Medical Technician will work harmoniously with and sustain confidence in Emergency Medical Technician associates, the nurses, the physicians, and other members of the Emergency Medical Services health care team.

The Emergency Medical Technician refuses to participate in unethical procedures, and assumes the responsibility to expose incompetence or unethical conduct of others to the appropriate authority in a proper and professional manner.

Adopted by: The National Association of Emergency Medical Technicians, 1978. Written by Charles Gillestie M.D.