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Resource Stewardship in Disasters: Alone at the Bedside

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ABSTRACT

Discussions about resource allocation commonly invoke concerns of unfair and variable decisions when physicians ration at the bedside. This concern is no less germane in disaster medicine, in which physicians make triage and allocation decisions under duress, and patients and their families may be challenged to self-advocate. Unfortunately, a real-time mechanism to support a process for ethical decision making may not be available to medical relief workers. Yet, resources for ethics decision support can be important for the moral well-being of the clinician, the ethical integrity of the relief effort, and to bolster the trust and confidence of the population receiving medical services. The need for clinical ethical support should be anticipated in disaster preparedness planning.

The dilemma so poignantly described by Michelle Daniel, MD, would trigger moral paralysis in many physicians.[1] To her credit, Daniel made reasoned and defensible decisions under duress and in a highly compressed time frame. Unfortunately, for Daniel and many other disaster relief medical workers, clinical ethical support is not a common feature of disaster medicine, whether that is an ethical briefing of triage scenarios likely to be encountered, or real time peer support for actual clinical dilemmas. One might argue that the unpredictability of the earthquake in Haiti and the enormity of the crisis allowed no time to attend to the ethics of disaster relief. Yet Daniel had "prior experience working in developing countries, including 15 months in Haiti," and was "assigned" by a well-established relief organization to her station in Port-au-Prince. The World Medical Association implies that ethical rules should be ". . . defined and taught beforehand."[2] The question was not *if* ethics support would be needed within the scope of disaster medicine, but rather *when* would it be needed.

For physicians at the bedside during disasters, triage is expectedly unavoidable. The Agency for Health Care Research and Quality (AHCRQ), in its report, *Altered Standards of Care in Mass Casualty Events,* recognizes that allocation decisions should follow a process that is "fair, open, transparent, accountable, and well understood by both professionals and the public. . . ."[3] Yet Daniel found herself without a

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real-time mechanism to support a process for decision making. This left her process of decision making closed, without external references for fairness, and accountable only to her personal sense of morality. It was a process not well understood by the public generally, or by her four patients who were assumedly disempowered by illness, illiteracy, and a culturally based deference to authority. This process of decision making was not well understood even by Daniel, whose grappling with the issues was contemporaneous to the crisis. Even though Daniel was mindful of the various competing objectives, interests, and biases that came to bear on her decisions, it is not fair to her, to other physicians similarly situated, or to the patients who bear the consequences of these decisions, to have individual physicians making allocation decisions without support. I suspect that Daniel would have had far less moral distress, anxiety, and concerns of *post-hoc* peer criticisms if her decisions were made with any sort of peer support or external referencing, particularly because her patients and their family members were not positioned to evaluate her actions.

Ultimately, Daniel's choice was most influenced by concerns of utility which, in times of *extremis,* often emerges over other relevant considerations as the least morally intolerable imperative for decision making. This application of utilitarianism, Kipnis submits, can be supported by two considerations: social contract and stewardship of resources.[4]

The social contract justification suggests that rational and reasonable members of a community would agree to some system of triage and allocation and would accept its consequences. Hence, healthcare workers would be ethically empowered to make decisions with reference to the triage priorities of a community, as long as these priorities are not unfair. It would require that triage and rationing be informed by domestic norms of culture, religion, and morality. For example, would the facts that, in Haitian culture, children are considered a gift, yet disease is considered a curse or punishment, influence the care of Daniel's 15-year-old girl patient?[5]

If such local input was never considered prior to a catastrophe, it is not likely to be integrated during a catastrophe. Therefore, physicians like Daniel may have little more than personal integrity with which to buffer utilitarian imperatives.

An additional buffer would have been for her to turn to her community of medical colleagues, whose professional values may provide an ethical framing for her dilemmatic decisions. This peer support can be critical in a physician's management of ethically dilemmatic cases and for managing one's moral distress. Peer support recognizes physicians as a community that is defined not only by expertise, but by experiences and respective moral weight attached to their role.

Reliance on peers alone can also be problematic, however, because the legitimacy, quality, and value of its product depend, in part, on the composition of the peer group and its processes for deliberation. The more insular a group is in composition, the greater the risk for groupthink and other decision-making biases. Moreover, if the group is wholly composed of internationally deployed emergency medical workers, its imported Western biomedical ethics may not resonate closely with some local norms.

Certainly, in times of crisis, the pull of utility can make attention to ethical congruence and fidelity seem irrelevant. However, to the extent that the need for ethical support can be anticipated, the disaster itself is no excuse for lack of preparation.

NOTES

1. M. Daniel, "Bedside Resource Stewardship in Disasters: A Provider's Dilemma Practicing in an Ethical Gap," in this issue of *JCE.*

2. *http://www.wma.net/en/30publications/10policies/d7/,* accessed 23 November 2012.

3. *http://archive.ahrq.gov/research/altstand,* accessed 10 November 2012.

4. K. Kipnis, "Overwhelming Casualties: Medical Ethics in a Time of Terror," *Accountability in Research* 10 (2003): 57-68.

5. *http://www.state.in.us/isdh/files/Haiti_Cultural_and_Clinical_Care_Presentation_Read-Only.pdf,* accessed 23 November 2012.