Doctors, Lawyers and Justice: When the Mass Disaster Happens

Medico-Legal Society: Laura Hawryluck, Joe Colangelo, Lee Akazaki

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LA Times: Fury Meets Katrina Hospital Arrests. Doctors defend the accused: 'The people who were not here' are to blame for deaths.

By Richard Fausset and Ann M. Simmons, Times Staff Writers, July 21, 2006

NEW ORLEANS — This week's arrest of a doctor and two nurses who stayed through Hurricane Katrina to care for stranded hospital patients — but are now accused of killing four of them — has prompted a strong backlash in the medical and legal communities here.

Some doctors saw the accusations leveled by Louisiana Atty. Gen. Charles C. Foti Jr. on Tuesday as brash, misguided moves that permanently smeared the reputation of three respected colleagues.

Others were disgusted that suspicion was being heaped on a small cadre of healthcare workers who stayed, at great personal risk, to tend to the sick — and in conditions that most American doctors have experienced only in wartime.

"This is vilifying the heroes," said Dr. Daniel Nuss, who supervises the accused doctor, Anna Pou, at the Louisiana State University Health Sciences Center. "I think it's presumptuous for the attorney general or anyone else to try to assign blame for what happened under such desperate circumstances."

Nuss said he was confident the suspects — all veteran caregivers with unblemished professional records — would be found not guilty.

Pou, 50, and nurses Lori L. Budo, 43, and Cheri A. Landry, 49, were booked Monday on suspicion of second-degree murder for allegedly injecting patients with lethal drugs at Memorial Medical Center on Sept. 1. It was three days after Katrina struck New Orleans, leaving the city in chaos and deep water. There was no electricity, water or phone service at the hospital, and only a few rescue boats were available for evacuations.

Pou, a head and neck cancer specialist, was given the opportunity to evacuate the hospital with others, but chose to stay and help patients, Nuss said. He believes her work in the days that followed was just as honorable.

"By personal accounts from nurses, doctors, administrators, and support personnel who knew Dr. Pou and had worked with her closely in the months before Katrina, her work during the crisis was 'heroic,' 'selfless' and 'distinguished,' " Nuss said in a prepared statement. "With other dedicated doctors and nurses, she worked without sleep and without nourishment…. At great self-sacrifice, she prevented further loss of life and has been credited with saving multiple people from dying.

"Apparently there were individuals in the hospital who could not understand why so many people were dying," Nuss' statement continued. "Allegations were made, egregiously accusing Dr. Pou and the others of giving too much narcotic pain medication, and even using the word 'euthanasia.' This attracted national news coverage, which became absurdly sensationalistic."

Pou, who was released on bail this week, has been reassigned to nonclinical research duties pending the outcome of her case.

The criticism of the criminal case is not limited to doctors who know Pou personally. Some other New Orleans doctors accused Foti, who plans to run for reelection in 2008, of grandstanding.

"Where the hell was he?" asked Dr. L. Lee Hamm of Tulane University School of Medicine, who helped care for stranded patients there after Katrina. "Where the hell was the law enforcement? Where the hell was anybody until Friday?"— Sept. 2, the day large-scale evacuations began in many areas.

"If you want to prosecute, if you want to know who is responsible for people dying, it's the people who were not

here," Hamm said. "It's not the people who were here."

Juzar Ali, a pulmonary-critical care doctor, stayed through the flood at Memorial's sister hospital, Lindy Boggs Medical Center, across town. Like Memorial, the hospital was surrounded by deep water and had lost electricity.

"We had no help — no help was in sight. And we felt abandoned. We didn't know what we were dealing with," he said.

Ali said he was "disturbed" by the attorney general's allegations, "because we don't really know the actual circumstances in which clinical decisions were made…. So as a peer it makes you feel for the physicians and the healthcare workers as to whether it's fair to project them as murderers."

Investigators allege the suspects killed four patients — all residents of a long-term care ward — with a drug cocktail of morphine and midazolam, which is commonly used to relieve pain and anxiety among long-term-care patients.

In an affidavit, a witness alleges that Pou said "lethal" doses of the drugs would be given to a number of patients on the ward.

Among the patients was a 380-pound paralyzed man who was "aware, conscious and alive," according to the affidavit.

Orleans Parish Dist. Atty. Eddie Jordan said Thursday that he would refer the cases to a grand jury, which would determine whether the suspects should be indicted. Foti's office has said more arrests and more victims will probably be announced.

Also on Thursday, a source close to the investigation who was unauthorized to talk about the specifics of the case said evidence could include testimony from one or more witnesses who participated in administering the drugs.

Some doctors interviewed acknowledged that they were not aware of all of the facts in the case. They also warned that prosecutors could find themselves treading on complicated legal and ethical terrain.

For instance, the affidavit noted that the bodies of the victims contained a "lethal amount" of morphine, and levels of midazolam that were "greater than expected from normal therapeutic doses."

But Ben deBoisblanc, a Louisiana State University medical professor and a doctor at Charity Hospital, said those kinds of quantifications could be tricky, because the amount of drugs needed to treat pain and anxiety could vary significantly from patient to patient.

"The attorney general can't tell from a [corpse's] drug level what's an appropriate dose," he said.

David Magnus, director of Stanford University's Center for Biomedical Ethics, defended a physician's right to help ease a patient's pain.

"Physicians are always allowed, and arguably obligated, to relieve the pain and suffering of their patients," he said, even when it risks killing them.

But Magnus said there was an impregnable ethical line defined by "the intention of the act." A doctor, he said, may administer drugs and view death as "a foreseeable and unintentional consequence." But a doctor may not intentionally kill a patient.

"I feel for the medical personnel, who were faced with this horrible situation," he said. "The patients can't be evacuated. You can't abandon them. You can treat them. These patients will probably die…. But to euthanize them against their will is ethically not an acceptable solution."

Some legal experts have criticized Foti, the attorney general, saying he crossed ethical boundaries in his news conference.

Harry Connick Sr., the Orleans Parish district attorney from 1974 to 2003, noted that Foti's office said the

suspects had been charged when in fact they had not been charged or indicted. In Louisiana, the attorney general can make an arrest on suspicion of a crime, but the district attorney must file the formal charge.

"All that occurred is an arrest," Connick said.

Timothy Meche, a New Orleans defense attorney who comments on legal issues for local media, said Foti's assertion that a homicide occurred appeared to violate Louisiana's rules of professional conduct for lawyers, which prohibit them from making public statements that would have the "substantial likelihood" of prejudicing a jury pool.

Foti spokeswoman Kris Wartelle said her office was within its rights as the investigating agency to call the news conference.

She said her office was "absolutely certain" that crimes occurred — and that they took extra care to be well prepared.

"This is a possible homicide committed by doctors who were highly esteemed professionals, who everybody thinks are gods — and in some cases they think they're gods," she said. "You don't waltz into these kinds of cases lightly."

Triage in Pandemics…. Can it be done ethically?

Laura Hawryluck, M.D.

Resource Allocation in Medicine:

Current scheme most commonly based on:

1. Need
2. First come, first served
3. Local hospital programs identified as priority by hospital or regional LHIN

Others have proposed access to healthcare resources take into consideration:

1. Importance to society e.g.: profession
2. Importance to others e.g. parents, caregiver, guardian, financial dependents
3. Utilitarian scheme: greatest good for greatest number

Questions for class discussion:

1. ***Should these personal characteristics weigh into rationing decisions?***
2. ***Just because of my importance to society or to my family should I deserve be placed at the head of the line?***
3. ***Is the greatest good for the greatest number a practical and ethical way to ration resources? Why or why not?***

Currently problems exist with needs/first come, first served scheme:

1. Can we meet the needs of everyone?
2. Can we provide consistent high quality care?
3. Are we using scarce resources effectively?
4. Do priority programs trump provision of healthcare to others with different needs?
5. Is there a time when likelihood of successful outcomes/ of benefits is so low that we consider it futile to offer certain treatments?

Some suggest a new scheme: Accountability for Reasonableness
(Dr Norman Daniels 1998):

Decisions based on reasons that "fair minded people can agree upon in face of resource constraints:

- Relevant
- Public (ie public is aware of criteria used)
- Enforced
- Appeals process (in case of disagreement/conflict"

(Daniels N, Sabin J. Health Aff (Millwood). 1998 Sep-Oct;17(5):50-64 and Daniels N., J Urban Health Jun 1999.)

Questions for Class discussion:

1. ***What problems do you see with Dr Daniels suggested model?***
2. ***Who decides what are relevant criteria in making these decisions?***

3. ***How can the public be informed?***
4. ***What about states such as Oregon where the general public had input into what medical treatments would be covered by state insurance? What problems arose?***
5. ***How do we achieve fair and just distribution of scarce healthcare resources? Can it ever be done?***

With the major innovations in technology we have seen, a fundamental question in Medicine today remains: "Just because I can, should I?"

To answer this question, issues of dignity, of values, beliefs, quality of life, benefits vs. burdens, resources and individual and collective societal goals come into play.

Questions for the Class discussion:

1. ***Who decides? Who balances these often competing issues? The Doctors? The Lawyers? The Courts? Government? Society as a whole?***

DISASTER SITUATIONS:
Such considerations for resource allocation as discussed above can be debated in everyday practice for it is a state of "luxury" compared to what we see in disaster situations such as SARS, Katrina or what is anticipated in advent of Pandemic flu

- 'Flu Surge' model: a 35% attack rate over 6 weeks
- Hospital admissions in Ontario for patient with influenza will peak at 1 823 per day.
- 72% of the total hospital capacity
- Demand for ICU resources will peak at 171% of current existing bed capacity and 118% of the current ventilator capacity solely for patients with influenza.
- Only takes into account physical system capacity and not the human capacity of the system

http://www.health.gov.on.ca/english/providers/program/emu/pan_flu/flusurge.html

An Effective Triage System Means:

1. Availability of accurate and up-to-date information about the natural history of the infectious agent, demands on the system, and resource availability.
2. A centralized triage advisory committee with command and control over resources
3. An efficient communications network that allows two-way communications between the "field" and the command centre
4. Trained triage officers in the field with the authority to make and enforce triage decisions

Christian M, Ontario Pandemic A/D/T Committee Report 2005

The Challenges:

- Lack of knowledge
- Lack of ability to predict

- Lack of treatment
- Changing nature of disease
- Secondary complications
- Communication/sharing of information
- Collection of data
- Sheer volume of patients
- Manpower issues
- Even "common" resources now scarce

In a Disaster situation: Fundamental shift in philosophy:

Acutely balance of needs of individuals and those of rest of the community

DO THE MOST FOR THE MOST: GREATEST GOOD FOR GREATEST NUMBER

Triage decisions depend on the patient's probability of survival AND on the availability of resources.

Triage will apply to all patients i.e. in a Pandemic flu to patients with influenza AND to all others

Ethics in Triage

- Fiduciary duty to patients and society
- In times of crisis need:
    - Trust
    - Transparency
    - Accountability
    - Well thought out/planned in advance
    - Coordinated approach

Lessons from Others

- Military has used triage systems for many years in mass trauma situations
- The sheer volume of people they are designed to sort make them useful in a disaster
- In Canada and the U.S. 4 category system of "immediate, delayed, minimal, or expectant" with corresponding number or colour code systems (red, yellow, green, blue colour coding)
- Triage officers to determine colour coding and subsequent access to resources
- Minimum qualifications for survival [MQS] to guide triage decisions:
    - Criteria which when met mean that an excessive quantity of resources would be expended for only a small probability of survival.
    - May be used to exclude patients from resources or to re-evaluate the patients' situation after admission

- When this threshold is reached healthcare would be transitioned from curative to palliation.

Questions for the class;

1. ***How could the triage of healthcare resources have been improved in Katrina disaster?***
2. ***How could the evacuation have been improved? (NB: the evacuation of private hospitals/facilities proceeded before level 1 hospital ie hospital in which sickest patients were treated)***
3. ***What would you do if you were caring for people, were running out of necessary treatments and could not evacuate them? What would you tell them?***
4. ***Is "euthanasia" in these situations ever justifiable?***