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**Disaster Ethics and Healthcare Personnel:
A Model Case Study to Facilitate the Decision Making Process**

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Abstract

The impact of Hurricane Katrina on the Gulf Coast signified the arrival of the most catastrophic natural disaster in United States history. Despite years of dire warnings, the absence of hurricane evacuation policies and disaster contingency plans highlighted not only staggering ineptitudes at all levels of government but at all levels of healthcare organization as well. Thousands of healthcare personnel and, in some instances, their families were stranded in New Orleans hospitals awaiting evacuation in rapidly deteriorating conditions. Many of these healthcare workers are not expected to return to New Orleans. Some of these decisions are infrastructure driven however, many are due to the psychological traumas experienced as a result of the ethically perpetuated conflicts they were, in some instances, forced to contend with. Familiarity with and utilization of a framework for ethical decision-making may facilitate healthcare professionals in maneuvering through disaster-instigated ethical dilemmas.

Keywords: Disaster, Ethics, Healthcare, Hurricane Katrina, New Orleans

INTRODUCTION

The annihilation of the Gulf Coast by Hurricane Katrina thrust the inadequacies of disaster and evacuation policies and practices at all levels of organizational and political government into the national spotlight. Images of stranded, desperate, dying and dead citizens initiated a fulcrum of viable questions and concerns. Perceptions of despair and imminent doom perpetuated the rationalization of physician-propagated euthanasia of the infirm, abandonment of the elderly and medical genocide of the hospitalized by those entrusted with maintaining the sanctity of human life. These actions instigated a cacophony of outrage, indignation, and criticisms. In an effort to expedite the façade of orderliness and normalcy in a place governed by chaos and deviancy, as well as provide a modicum of psychological tranquility for the country's horrified bystanders; assurances, pacifications, and pledges of investigation and retribution were commonplace. The concrete practicality of this methodology, however, does not consider the degree of abstraction inherent within the complex determination of resolutions and implications generated as a result of the personal, professional, and employer-employee dilemmas a catastrophe of this magnitude created for not only the healthcare recipients but for the healthcare providers as well.

According to the U.S. Department of Labor (2005), registered nurses comprise the largest group of healthcare personnel. The majority of registered nurses (three out of every five) are employed as clinicians in acute care hospitals where they are responsible for providing direct care to the physiologically and or psychologically compromised. In this setting, the prevailing ethical conflicts are most often client-driven and are most frequently associated with issues of well-being, choice, privacy, and cost/insurance reimbursement. The proximity of the client-nurse relationship facilitates the nurse's involvement in various stages of the ethics procedural process. Therefore, nurse clinicians, administrators, educators, and researchers within these

facilities may often find themselves involved in and or impacted by the ethics inherent to the delivery of healthcare services. In addition, federal and state regulatory agencies often require that specified breeches of ethical standards and suspected ethical misconduct be reported, tracked, and a corrective action plan is developed and implemented. Punitive penalties in the form of monetary disbursements may also be levied on offending organizations (Department of Justice, 2003). For this reason, ethical dilemmas that are wholly client-centered may well appear to be the customary model.

While national healthcare organizations and professional associations (e.g. American Hospital Association, American Nurses Association, and American College of Healthcare Professionals) advocate the utilization of codes of ethics at all institutional levels, ethical analyses of institutional policies and procedures that impact the psychological and personal well-being of nursing personnel appear to be regulated less stringently. In addition, the initiatives that are promoted to advance policies dedicated to the wellbeing of nurses is relegated to the sector of workplace advocacy and continue to focus on client-driven safety and outcomes measures despite the plethora of studies implicating stress and ethical ramifications, among other variables, as growing concerns for nurses (Knox & Irving, 1997; Debarck & Cohen, 1996). As such, there appear to be widespread disconnects regarding the emphasis that healthcare workers place on personal and familial interests as well as how these issues impact policy development and implementation. This is particularly significant in geographically susceptible areas of the gulf coast where inclement weather poses the threat of catastrophic destruction and therefore, the increased probability of ethics-driven scenarios requiring resolutions derived from a reliable decision-making model.

BACKGROUND

Geography

The greater New Orleans Metropolitan area is comprised of eight parishes, (Jefferson, Orleans, Plaquemines, St. Bernard, St. Charles, St. John, St. James, St. Tammany), that is home to approximately 1.4 million people and is the 35th largest metropolitan in the United States. According to the U.S. Census Bureau (2003), New Orleans is the largest city in Louisiana with approximately 500,000 residents living in a 500 square mile radius, 50% of which is water. This major port city is 100 miles upriver from the Gulf of Mexico with the Mississippi river running along its Southern border and Lake Pontchartrain traversing its Northern edge. New Orleans is the third lowest elevation point in the United States with approximately 50% of the city sitting 1-10 feet below sea level. The “bowl” effect often described is a result of the city’s hydrologic surroundings and depressed elevation.

Meteorology

Due to its location and surroundings, flooding and hurricanes are as much a part of the fabric of New Orleans as Jazz and Mardi Gras. According to the National Hurricane Center 2005 statistics, from 1851-2004, Louisiana has been assaulted by 49 hurricanes. Approximately 1/3 of these hurricanes are categorized as major, five are among the costliest in U.S history and 11 are among the most intense to ever make landfall in the U.S. It is of interest to note that these statistics do not include tropical storm systems that made landfall in the area. Despite these hurricane trend indicators and multitudes of predictions and theories (Fischetti, 2001) brought forth by meteorological experts regarding the fate of New Orleans in the event of a direct assault from a major hurricane, it has become extremely clear that no one in the government or

industrial communities had adequate evacuation and or contingency plans developed, evaluated, and ready for implementation.

Hurricane Katrina

According to the National Hurricane Center (2005), on Monday, August 29, 2005, a forecasted category four hurricane with sustained winds of 135 mph winds battered New Orleans with storm surges of 15-20 feet above normal tide levels. These surges were responsible for three major levee breaches and catastrophic flooding in over 80% of the city. As a result, one of the most famous cities in the world was reduced to un-inhabitability; its infrastructure left in ruin, and greater than 99% of its populace ultimately scattered throughout the continental U.S.; a first in recorded history. Hurricane Katrina was the sixth strongest Atlantic hurricane ever recorded and the third strongest to make landfall in the U.S. The death toll has reached nearly 2000 in Louisiana alone, over 700 of which were in New Orleans. Total damages are projected at \$81 billion, making Hurricane Katrina the costliest disaster in U.S. history (Wikipedia, 2005).

Healthcare Demographics

According to the Center for American Progress (2006), there were approximately 34 acute care hospitals operating in the New Orleans metropolitan area with a total bed capacity of 5,707 employing approximately 10,000 licensed nurses. These facilities included a major VA medical center, the largest state-funded health sciences /level 1 trauma center, a regional children's acute/ambulatory care facility, and several other non-profit and for-profit medical centers with bed capacities greater than 400. Within the city, all of the hospitals had nursing staff and staff family members stranded in the aftermath of Hurricane Katrina that required evacuation. The

length of stay within the confines of the hospitals prior to being evacuated ranged from 48-160 hours. All of the hospitals in the city of New Orleans were ultimately closed. Currently, only Touro Infirmary and Children's Hospital are operating at near normal pre-Katrina capacity. However, greater than 50% of the licensed nurses currently employed at these healthcare facilities are either contract or per diem agency employees.

WORKPLACE ADVOCACY

The American Nurses Association (ANA) does not have a position statement that addresses workplace advocacy issues for registered nurses who live in and or employed in areas that are at high risk for catastrophic outcomes as a result of natural disasters. Current position statements address issues involving the rights, responsibilities, and deployment of registered nurses to disaster areas post-disaster (ANA, 2002a & 2002b). However, provision 5 of the ANA code of ethics (2001) states that "the nurse owes the same duties to self as to others". Indeed the ANA also recognizes that the nurse's professional and personal lives are entwined and that duty to self is in itself symbolic of wholeness of character.

The Louisiana State Board of Nursing (LSBN) does not provide declaratory statements on employee-employer related issues. Similar to the ANA, there is a declaratory statement regarding the deployment of Louisiana nurses to disaster areas as well as endorsements of outside nurses that volunteer to work in Louisiana post-disaster. The LSBN does, however, define abandonment as "leaving a nursing assignment without properly notifying the appropriate personnel" (LSBN, 2002, p.12). Despite the position regarding employee-employer issues, the Board does not preclude the submission of any nurse for investigatory review for possible disciplinary action. The merit, and therefore the initiation and progression of disciplinary action,

of each submission are reviewed on a case-by-case basis. However, there is no precedence for outcomes that place the nurse and or their families in imminent danger. Without an objective evaluative instrument to guide the investigatory process, decisions formulated by these nurses must support all competing perspectives and must therefore be judgmentally and justifiably sound.

ETHICAL DECISION MAKING

Ethics refer to standards of behavior that guide a proper response to various circumstances. Although neither beliefs, feelings, religion, law, culture, nor science are ethical decision-making antecedents (Markkula Center for Applied Ethics, 2006), an individual's intrinsic character often precludes the exemption of these variables in thought or deed. Indeed, dilemma complexity, experiential competence, implementation brevity, and the lack of familiarity with an applicable framework to guide the decision-making process could prove to be morally and professionally ruinous, particularly for novice decision makers. In addition to and unlike the indirect relationship and affect of a client-driven crisis, the direct dyadic relationship of the nurse as both benefactor and recipient of the decisional outcome creates an internal dynamic that may be distinctly autonomous for this population. Although a dearth of information on ethics, ethical decision-making, and decision making models is available on a continuum from global to specific, the complexity of the decision-making process for nurses, particularly in the face of duress, may require re-examination of current models and or the reflection of these themes in future models.

To facilitate the application of the ethical decision-making process, a conceptual model that is both comprehensive in scope and simplistically understandable is presented. This conceptual

model is an eclectic paradigm integration of components from the nursing process, the theory of biomedical principles, and philosophical ethical perspectives. The proposed model illustrates the inter-relationships among these components to promote and facilitate the ethical decision making process.

The first model component, an adaptation of the nursing process, is a theoretically simplistic, cyclical, process for deliberative, systematic, and organized problem solving (Fawcett, 2000). Because of its extensive use in clinical decision making, the introduction of this method during undergraduate education promotes its utility for nurses within this model. To this extent, only four (i.e. assessment, planning, implementation, and evaluation) of its five concepts are utilized. The concept of diagnosis, as a clinically driven platform, has been omitted. Similar to Cassell's and Gaul's (1998) ethical assessment framework for patient-outcomes decision making, the nursing process as a standard for its analytic maneuvering is well documented throughout the healthcare literature. As such, its applicability to ethical decision-making that is nurse-driven is logically concluded and thus is the fundamental foundation for this model.

The second component of this framework integrates the theoretical components of principlism, an ethical decision-making presented by Beauchamp and Childress (1994, 2001) that has become a staple for applied ethics. The four principles central to this approach are autonomy, non-maleficence, beneficence, and justice. It is beyond the scope of this manuscript to detail these works. However, a brief overview of these concepts is provided in Table 1 for purposes of model translation and usage. Similar to the components of the nursing process, all of the components must be deliberated, whether consecutively or simultaneously, and a goodness-of-fit determination established that is situation specific. This stage of the framework is an element of the planning phase of the nursing process.

Table 1
Beauchamp and Childress (1994) theoretical components of principlism with corresponding descriptives.

Component	Descriptive
Autonomy	Freedom from controlling interferences and personal limitations that prevent meaningful choices. Essential components include liberty and the capacity for intentional action.
Non-maleficence	Do no intentional harm. Standard of due care.
Beneficence	Actions contribute to the welfare of others. Requires that positives and negatives be balanced.
Justice	Fair, equitable, and appropriate treatment taking into consideration what is due or owed.

The third and final component of this framework designated “Initiators of Conduct”, is reflective of organizational, professional, and personal standards, codes, regulatory statutes, and policies and procedures. Either a working intelligence regarding these subjects or readily available resources for examination is a necessity at this stage. These elements may also be considered consecutively or simultaneously. It is of importance to note that the resultant decisions formed as a result of this analysis will in all likelihood impact the interpretation of the components of principlism within in this model. Figure 1 is a schematic representation of the model and its associated components. The model process is initiated when an ethical issue is believed to exist. As a result, a determination is made (assessment) of the ethical issue at hand. An action plan should then be developed based on the components of principlism and the initiators of conduct. Implement the plan of action and evaluate the actions success in achieving the goal.

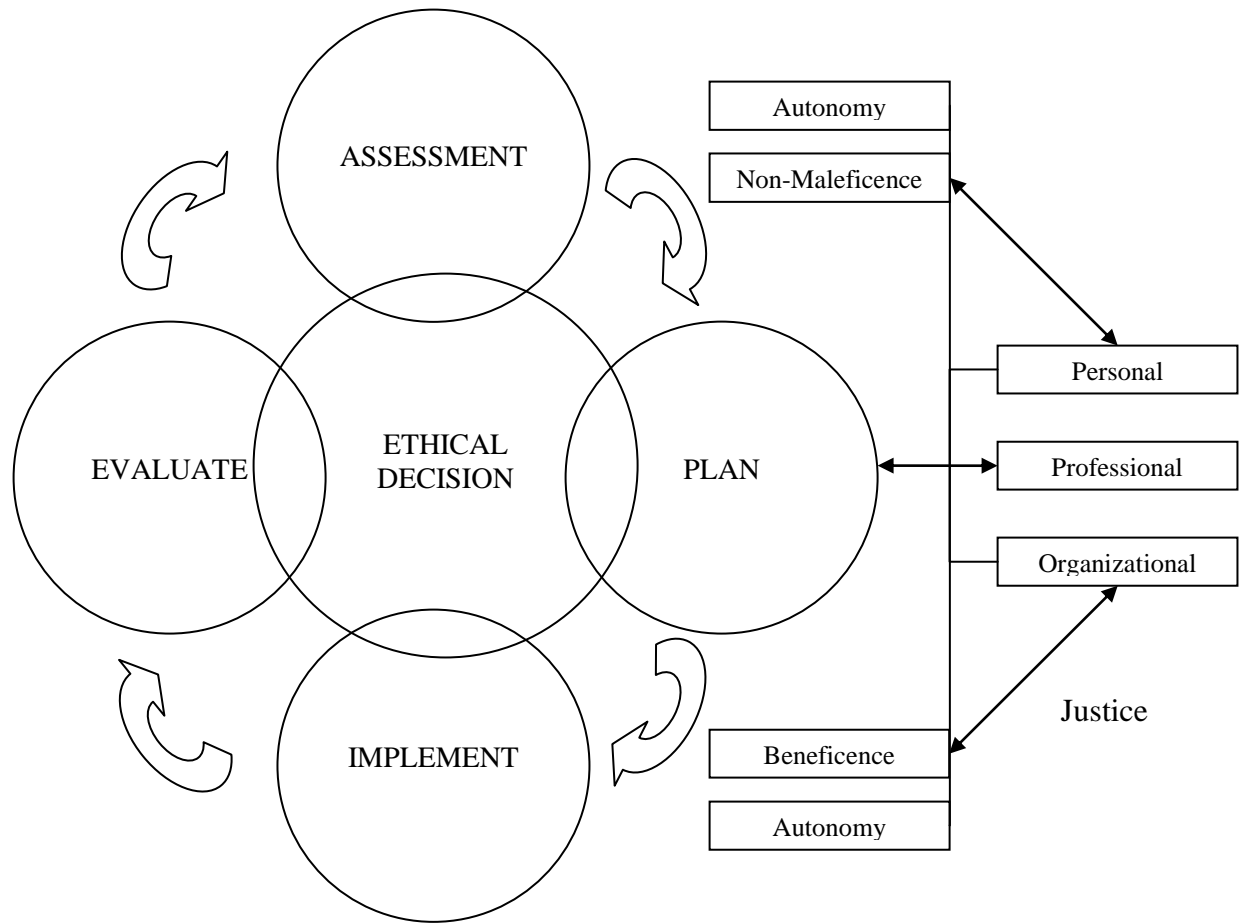


Figure 1: Proposed conceptual schematic of a dyadic nurse-centered decision making framework

CASE STUDY

The case study that follows is an adaptation of an actual ethical crisis that confronted nurse clinicians and administrators in New Orleans, Louisiana as a result of the imminent collision of the city and its inhabitants with Hurricane Katrina. This case study is designed to afford the reader an opportunity to: (a) develop potential resolutions via the integration of professional and personal ethics and reasoning; (b) reflect on the psychological impact of morale decision-making processes during a crisis; (c) stimulate dialogue regarding self and or family-preservation versus organizational responsibility; and (d) evaluate the responsibility of nursing's national and state governance in developing a position statement regarding issues of imminent danger versus dereliction of duty.

David is employed as a staff nurse at a 300-bed tertiary care facility in uptown New Orleans. The hospital's staffing solution for its hurricane response plan was the creation of a three (3) tier nursing response team. The nurses assigned to tiers 1 and 2 were considered essential and would be expected to report to the hospital to provide patient care during the hours before (usually 24 hours), during, and after (usually 12 hours) the hurricane's arrival and departure. During this time, the hospital would go into a "lock-in" mode where no employee was allowed to enter or leave the premises regardless of their shift assignment. Once the "lock-in" phase of the hurricane plan has ended, it is the responsibility of the members on tier 3 to provide a recovery and relief period for those persons on tiers 1 and 2.

David and his wife are preparing to evacuate New Orleans for Hurricane Katrina. He receives a phone call from a friend who is a tier 1 member requesting that David stop by the pharmacy, pick up some toiletries, and drop them off on his way out of town. David arrives at

the hospital and is greeted with the news that the first mandatory evacuation call has caused a mass exodus from the city and over 75% of the members of tiers 1 and 2 are evacuating the city. David's wife is an insulin dependent diabetic who is on a strict dietary, medication, and exercise regime. As a result, David has never accepted a position that would designate him as essential personnel. David has, however, never failed to report to work as a tier 3 relief member. The nursing administrator pleads with David to stay and assist and is assured that he and his wife will have suitable lodging and that her medical and dietary needs will be attended to accordingly.

There are more than 2000 employees, family members, and pets sheltered in the hospital. Eight hours post Katrina, there is only essential electricity and water and food has begun to be rationed. There will be no tier 3 nursing personnel relief because entrance into the city has been halted as a result of the devastation. David has just completed a 12-hour shift tour when his wife informed him that her blood glucose is 276. Unknown to David, her diabetic meals have been altered as a result of food and water rationing. In addition, the diversion of electricity has left her insulin in an uncontrolled environment. David locates the nursing administrator and gives notification that he is leaving due to his wife's condition. David is informed that if his wife's condition worsens she will be cared for, but leaving the hospital at this time will constitute job abandonment and will be reported to the Louisiana State Board of Nursing.

DISCUSSION

Utilizing the previously described decision-making framework, review the questions below and formulate possible solutions. Keep in mind, this is a dyadic nurse-driven model where the outcome will directly impact not only those involved clients but the nurses and their families as well. This exercise can be completed as an individual or group endeavor.

- (a) Was David's decision the most appropriate decision?
- (b) If placed in the same position, what would your decision have been?
- (c) Were there any other ethically sound options that David could have employed?
- (d) Should professional and governing organizations for nursing declare a position?

Regarding nurses who live and or work in high-risk areas of the country?

- (e) Was the nursing administrator's decision ethically sound?
- (f) Should David receive a state board reprimanded for his actions?
- (g) Should the nursing members of tiers 1 and 2 receive a state board reprimand for not reporting to work?

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