Disaster ethics: What are the ground rules?

3 cases can help you make appropriate decisions when priorities suddenly change

Bioethics of clinical practice change during disasters, as our staff learned when providing emergency care to Hurricane Katrina evacuees. During crises such as severe weather, terrorist acts, and epidemics, physicians can be torn between advocating for individual patients’ needs or the public good.1

As the storm’s 2-year anniversary approaches (Box, page 70),2,3 we share our experiences to help you prepare for disasters in your community and to contribute to the limited data on ethics in disaster psychiatry. This article describes 3 cases to show how mental health clinicians balanced issues such as conflict, consequences, patient rights, physician virtues, and justice when making treatment decisions in the Houston Astrodome clinic.

CASE 1

Benzodiazepines for anxiety?

Mr. R, age 23, presented to the Astrodome mental health clinic requesting “Xanax for my nerves.” He said he had been taking 6 mg/d “for years and years, and it’s the only thing that helps.” Mr. R claimed he had been without his medicines at least 48 hours.

The assessing psychiatrist found no evidence of benzodiazepine withdrawal or other psychiatric emergency. The dilemma: How to provide appropriate acute treatment of a chronic problem, without continuity of care and follow-up.

As a hurricane survivor, Mr. R experienced a traumatic event that could have exacerbated an underlying anxiety disorder. But patients’ use of and physicians’
prescription of benzo diazepines can have adverse short- and long-term consequences. Mr. R’s case highlights the conflict between establishing patient-physician trust vs enabling a patient’s suspected misuse of prescription medication.

In the Astrodome clinic:
12-hour shifts, rapid assessments

Hurricane Katrina struck August 29, 2005, causing >1,000 deaths and displacing several hundred thousand Gulf Coast residents. Nearly 25,000 New Orleans evacuees were bused to the Houston Astrodome, where the medical clinic logged 11,000 patient visits in 15 days (including >1,000 to the mental health clinic).

I joined a mental health team that met the first evacuees, who arrived disheveled, exhausted, and hungry at 5 AM. Many had chronic psychiatric disorders and had lost their medications in the flood. Mental health teams from Houston and elsewhere staffed the clinic around the clock to address the patients’ issues, including schizophrenia, depression, and anxiety.

Limited resources and privacy
Patients streamed through the clinic 24 hours a day, the vinyl sheets between “exam rooms” providing a modicum of privacy. Resources were limited, and we performed assessments much more rapidly than my usual 1-hour initial evaluation. I worked 12-hour shifts for 10 days until I developed the fever (104 °F) and infectious diarrhea that spread among patients and clinic workers.

Some patients arrived requesting “little round white pills” that had quieted their hallucinations, but we had no way to retrieve records destroyed in New Orleans pharmacies. Sometimes we carried backpacks filled with medicines and made “rounds” to patients who were afraid to leave their cots for fear of losing their beds.

Missing neonate
In one case, our team helped a distressed couple find a newborn who had been evacuated from a Louisiana hospital ICU to an unknown location. After several hours, we located the baby in a Texas hospital. In appreciation, the baby’s mother returned the next day to volunteer with us.

Managing patient care during a disaster was a powerful experience. I think about the evacuees often and hope I made a difference in their new beginnings.

Jennifer E. Pate, MD
### Ethical principles that guide disaster psychiatry

<table>
<thead>
<tr>
<th>Principle</th>
<th>Definition</th>
<th>Example</th>
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<tr>
<td>Respect for autonomy</td>
<td>Promotion of and respect for the patient with capacity to make informed, voluntary decisions about his or her healthcare</td>
<td>A competent patient must provide voluntary informed consent to be admitted to an inpatient psychiatric facility</td>
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<tr>
<td>Beneficence</td>
<td>The commitment to act in a manner that brings about benefit or a good outcome</td>
<td>During an emergency, a physician overrides a patient’s confidentiality to inform his mother of his location</td>
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<tr>
<td>Nonmaleficence</td>
<td>An obligation to avoid doing harm</td>
<td>Physician refuses to prescribe potentially harmful medication to a patient with an addiction</td>
</tr>
<tr>
<td>Justice</td>
<td>“Fair” distribution of healthcare resources</td>
<td>Each patient receives care according to need or as resources are available</td>
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Source: Adapted from reference 11

Few guidelines exist to help clinicians manage trauma patients immediately after a disaster. Until recently, debriefing was thought to help prevent posttraumatic stress disorder (PTSD), but multiple studies indicate that debriefing is not effective and may worsen psychological outcomes. Recommended postdisaster treatment now integrates 4 elements:

- providing for basic needs (food, shelter, clothing, and safety)
- psychological first aid
- needs assessment
- psychoeducation about normal responses to disasters.

Data support stress-reducing programs—such as yoga-based trauma relief—that may effectively and economically ameliorate trauma-related psychiatric symptoms.

To make its decisions, the Astrodome clinic team considered the potential problems of prescribing benzodiazepines to patients such as Mr. R:

- Large numbers of traumatized victims might visit the clinic to request benzodiazepines, addictive drugs that for many would be inappropriate and potentially harmful.
- Resources such as medications, information, and time were limited. The team could not contact each patient’s health care provider or pharmacy to verify prescription records.
- Using benzodiazepines to manage anxiety in the acute aftermath of a traumatic event is not supported by the literature.

The team then designed a plan based on published guidelines to do the least harm (nonmaleficence) and provide the greatest benefit (beneficence) with limited resources. They chose to assess each patient’s case individually.

In general, patients were not given benzodiazepines for acute anxiety or acute stress disorder. Evacuees who presented to the clinic were educated about normal responses to trauma, received supportive care, and were referred to on-site social service agencies for help finding housing and lost family members.

**CASE 2**

**Urgent care for chronic illness?**

Ms. J, age 46, presented to the mental health clinic for evaluation and treatment of chronic depression and anxiety. When asked how she was coping with the storm, she replied, “I wasn’t in the storm. I live in Houston, and I’ve been waiting 6 months to see doctors at the public hospital. I decided to come here and see everyone I needed to see.”

Because of news coverage, Houston residents were well-informed about the hurricane and the Astrodome clinics. Ms. J was resourceful in seeking needed treatment.

The Astrodome clinics were intended to provide acute care to evacuees who lacked alternate resources. Ms. J had chronic mental health problems, but her symptoms could have been exacerbated by graphic...
Disaster psychiatry

**Clinical Point**

During emergencies, HIPAA allows you to share information as needed to notify families of a patient’s location, general condition, or death.

media reports of the storm’s devastation. A challenge in treating chronic health problems in an acute setting is the inability to provide follow-up and continuity of care. An “emergency” clinic is meant to serve as a bridge to later care providers.

Four principles guide ethical decision-making: respect for autonomy, beneficence, nonmaleficence, and justice (Table 1, page 71). Would it be an injustice to allocate scarce resources—number of personnel, physician time, space, and medication—to a patient with chronic rather than acute needs?

One could argue that a patient-physician relationship and duty to treat began when Ms. J presented herself as a patient in need and began a dialogue with a physician. The treating physician felt Ms. J’s interest would be served best by continuing the evaluation and acutely managing her symptoms while trying to help her obtain treatment in a more stable setting.

The staff correctly anticipated that this case was unique; no other patients who were not evacuees are known to have requested treatment at the Astrodome clinic.

**CASE 1**

Compassion vs confidentiality

Mrs. C, age 67, came to the mental health clinic in tears because she had been separated from her son when she boarded a bus to evacuate from New Orleans. Her son has schizophrenia, and she asked if we had seen him at our clinic. In fact, he had visited our clinic shortly before she arrived.

As healthcare professionals, we value compassion but also are bound by tenets of the physician-patient relationship—in this case, maintaining confidentiality. Physicians are ethically and legally obligated to refrain from disclosing information obtained from a patient without the patient’s permission.

Mrs. C was clearly distressed, however, and if one considered her also to be a patient then providing the information she requested could benefit her well-being. She knew her son’s diagnosis, so there would be no “new” disclosure of medical information if clinic staff answered her question. Furthermore, Health Insurance Portability and Accountability Act (HIPAA) regulations for emergency situations aid in making similar decisions. The law states:

“Health care providers can share patient information as necessary to provide treatment. Health care providers can share patient information as necessary to identify, locate, and notify family members, guardians, or anyone else responsible for the individual’s care of the individual’s location, general condition, or death.”

**Bottom Line**

Ethical practice during disasters calls for doing the least harm (nonmaleficence) and providing the greatest benefit (beneficence), often with limited resources. In emergencies, usual tenets of the physician-patient relationship, such as maintaining confidentiality, are sometimes overruled by the need to provide for patients’ well-being.

<table>
<thead>
<tr>
<th>Table 2</th>
<th>Emotional dynamics that motivate disaster response</th>
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<tr>
<td>Altruism</td>
<td>Courage</td>
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<tr>
<td>Empathy</td>
<td>Compassion</td>
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<tr>
<td>Confrontation with mortality</td>
<td>Loss of personal sense of invulnerability</td>
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<tr>
<td>Identification with those affected</td>
<td>Relief at survival</td>
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<tr>
<td>Reminders of past experiences</td>
<td>Wish to undo harm and “do good”</td>
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<tr>
<td>Guilt about being unaffected</td>
<td>Feelings of affiliation</td>
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Source: Reference 13
highest dose of oral olanzapine (15±2.5 mg). In controlled clinical trials of intramuscular olanzapine for injection, there were no statistically significant differences from placebo in occurrence of any treatment-emergent adverse events, except the following: somnolence, assessed by either rating scales incidence or spontaneously reported adverse events.

Other Adverse Events: Use-relatedness of adverse events was assessed using data from this same clinical trial involving 3 fixed oral dosage ranges (5±2.5, 10±2.5, or 15±2.5 mg) compared with placebo. The following treatment-emergent adverse events occurred in a statistically significant trend: asthenia, dry mouth, nausea, somnolence, tremor.

In a 8-week, randomized, double-blind study with schizophrenia, schizoaffective disorder, or obsessive-compulsive disorder compared fixed doses of 10, 20, and 40 mg, statistically significant differences were seen between doses for the following: baseline to endpoint weight gain, 10 vs 20 mg; incidence of treatment-emergent prolactin elevations: 24.2% (10 mg), 19.3% (20 mg), and 13.4% (40 mg); and 20 vs 40 mg: fatigue, 10 vs 40 mg and 20 vs 40 mg: diarrhea, 20 vs 40 mg.

Table 2: Changes—Oral olanzapine was associated with orthostatic hypotension and tachycardia in clinical trials. Intramuscular-olanzapine for injection was associated with Bradykinesia, hypotension, and tachycardia in clinical trials (see PRECAUTIONS).

Table 3: Adverse Events Occurring in ≥5% of Oral Olanzapine Patients in Clinical Trials—The following treatment-emergent events were reported with oral olanzapine at doses ≥1 mg in clinical trials (861 patients, 4165 patient-years of exposure). This list may not include events previously listed elsewhere in labeling, those events which were remote in time, those events which were so general as to be uninformative, and those events reported only once or twice which did not have a substantial probability of being caused by the drug. All events occurring in ≥5% of all patients in clinical trials of fixed oral dosage ranges compared to placebo-treated patients (N=1415) with a mean decrease of 4.6 mg/dL from a mean baseline of 175 mg/dL. In placebo-controlled trials, olanzapine-treated patients with the following treatment-emergent events showed a statistically significant trend: asthenia, diaphoresis, fatigue, headache, hypotension, insomnia, malaise, somnolence, syncope, and tachycardia in clinical trials (728 patients, 10,651 patient-years of exposure). There was no indication of a risk of clinically significant neuropenia associated with olanzapine in the premarketing database.

Table 4: Adverse Events Occurring in ≥5% of Intramuscular Olanzapine Patients in Clinical Trials—The following treatment-emergent events were reported with intramuscular olanzapine for injection at doses ≥1 mg in clinical trials (1413 patients, 6445 patient-years of exposure). This list may not include events previously listed elsewhere in labeling, those events which were remote in time, those events which were so general as to be uninformative, and those events reported only once or twice which did not have a substantial probability of being caused by the drug. All events occurring in ≥5% of all patients in clinical trials of fixed intramuscular dosage ranges compared to placebo-treated patients (N=1415) with a mean decrease of 4.6 mg/dL from a mean baseline of 175 mg/dL.

In an 8-week, randomized, double-blind study with schizophrenia, schizophreniform disorder, schizoaffective disorder, or obsessive-compulsive disorder compared fixed doses of 10, 20, and 40 mg, statistically significant differences were seen between doses for the following: baseline to endpoint weight gain, 10 vs 20 mg; incidence of treatment-emergent prolactin elevations: 24.2% (10 mg), 19.3% (20 mg), and 13.4% (40 mg); and 20 vs 40 mg: fatigue, 10 vs 40 mg and 20 vs 40 mg: diarrhea, 20 vs 40 mg.

Table 2, page 72

| Therapeutic resources | Catastrophes evoke powerful emotions that can blur responders’ therapeutic boundaries and interfere with how we care for individuals in need (Table 2, page 72). 13 Some Web-based resources to help you prepare for disasters are available from: | http://psychiatry.uc.edu/ | clinical/disastermentalhealth.html |

Based on these arguments, the treatment team believed that working with Mrs. C and, if necessary, informing her of her son’s location outweighed the conflicting need to maintain his right to confidentiality.


References