

# LESSON 6-1

## ETHICAL LEGAL

**Lesson:** Ethical legal

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### Intended Audience of Learners

A broad range of health professionals who may work with the older adult population.

### Competencies

This lesson supports learning related to the following competencies, with regard to *ethical-legal special considerations for the geriatric population in disasters*.

Core Competencies and Subcompetencies from [Walsh L, Subbarao I, Gebbie K, et al. Core competencies for disaster medicine and public health. \*Disaster Med Public Health Prep.\* 2012;6\(1\):44-52. doi: 10.1001/dmp.2012.4.](#)

Core Competency 9.0 "Demonstrate knowledge of ethical principles to protect the health and safety of all ages, populations, and communities affected by a disaster or public health emergency."

Subcompetency 9.1 "Discuss ethical issues likely to be encountered in disasters and public health emergencies."

Subcompetency 9.2 "Describe ethical issues and challenges associated with crisis standards of care in a disaster or public health emergency."

Subcompetency 9.3 "Describe ethical issues and challenges associated with allocation of scarce resources implemented in a disaster or public health emergency."

Core Competency 10.0 "Demonstrate knowledge of legal principles to protect the health and safety of all ages, populations, and communities affected by a disaster or public health emergency."

Subcompetency 10.1 "Describe legal and regulatory issues likely to be

encountered in disasters and public health emergencies.”

Subcompetency 10.2 “Describe legal issues and challenges impacting patient care in a disaster or public health emergency.”

Subcompetency 10.3 “Describe legal issues and challenges associated with allocation of scarce resources implemented in a disaster or public health emergency.”

Subcompetency 10.4 “Describe legal statutes related to health care delivery that may be activated or modified under a state or federal declaration of disaster or public health emergency.”

### Learning Objectives

At the end of this lesson, the learner will be able to:

- 6-1.1 Name 3 or more ways in which a disaster can heighten the vulnerability of elderly people.
- 6-1.2 Discuss 3 or more ways in which emergency preparedness can benefit vulnerable elderly when health care resources are scarce.
- 6-1.3 Discuss the potential limits of patient autonomy in a public health emergency or disaster for (a) adults with decisional capacity, and (b) adults who lack decisional capacity.
- 6-1.4 Discuss individual state resources that providers can consult regarding state-specific regulations covering the participation of unaffiliated providers and other volunteers in a disaster.

### Estimated Time to Complete This Lesson

120 Minutes

### Content Outline

Module 6: Ethical legal: Special considerations for older adults

Lesson 6-1: Ethical legal

- I. Lesson - The extraordinary circumstances in a disaster
  - a. Introduction
    - i. The American experience with disasters demands answers to the difficult questions of how to handle a disaster’s extraordinary demands, particularly in this society, which is accustomed to reliance on a stable, albeit imperfect health care system. The search for answers has led to ongoing efforts to develop guidelines that would measure up to our expectations of what should be, in the context of scarce resources, overwhelmed hospitals, equipment shortages, and the many and varied

circumstances that could exist. In this context, appropriate care of the elderly creates special concerns. Among the many concerns, this module focuses on ethical and legal issues that should be familiar to all who would be involved with these efforts.

- b. Crisis Standard of Care definition (Institute of Medicine): “a state of being that indicates a substantial change in health care operations and the level of care that can be delivered in a public health emergency, justified by specific circumstances. Medical care delivered during disasters shifts beyond focusing on individuals to promoting the thoughtful stewardship of limited resources intended to result in the best possible health outcomes for the population as a whole.”<sup>1</sup>
  - i. Caveat: Crisis standard of care does not indicate “substandard care.” For example, the American College of Emergency Physicians (ACEP) guidelines note: “...crisis care is what a reasonable practitioner would do (and want for himself and his loved ones), given the limited resources at hand.”<sup>2</sup>
  - ii. The multiple considerations of this complex topic are beyond the scope of the present lesson. For detailed information on Crisis Standards of Care, consult Supplemental Readings for Learners and Required Resources for Educators: Hanfling D, Hick J, Stroud C. *Committee on Crisis Standards of Care: A Toolkit for Indicators and Triggers*, National Academies Press, 2013.
- c. Duty to plan
  - i. Assess adequacy of health care resources and supplies.
  - ii. Identify individuals who are likely to have special needs during an emergency. Of note, some of these individuals may not self-identify, particularly if they are homebound or cognitively impaired.
  - iii. Identify or develop methods of providing health care to those with special needs, such as special needs shelters, in-place sheltering, and volunteer and staff training, among others.
  - iv. Identify obstacles related to liability concerns. For example, some health care institutions may restrict or prohibit family and other nonprofessional volunteers from assisting in functions such as feeding and toileting, despite the potential value of this source of care. In a disaster, the need for such volunteers is greatly augmented.
  - v. Become familiar with “disaster law” and ways in which its provisions can be activated or modified in a declared disaster or public health emergency.

- d. Applying “disaster law” in geriatric care
- i. Emergency declaration: When a designated person (e.g., governor of a state, Secretary of Health and Human Services) declares an emergency, this can trigger a framework for various allowances (e.g., who can volunteer) and restrictions (e.g., quarantine) during an emergency.
  - ii. Emergency licensing and credentialing
    1. Across state lines
      - a. Health care providers who live outside a state or community affected by an emergency may be willing and able to provide necessary assistance, but delays in obtaining authorization, such as licensure in the host state, or credentialing, can prevent such health care workers from providing useful help.<sup>3</sup>
      - b. Certain states allow their governments, during a declared emergency, to give reciprocity to providers licensed in other states who volunteer so they can provide services without having to go through the host state’s formal licensing process.<sup>4,5</sup>
    2. Unaffiliated clinical volunteers from the community.
      - a. Certain organizations and accrediting bodies, such as the Joint Commission,<sup>6</sup> address emergency credentialing of categories of persons who might volunteer during an emergency. These include “volunteer licensed independent practitioners” (those who are permitted by a state’s law to provide care without direction or supervision) and volunteer practitioners who are not “independent,” but are still required by law or regulation to be certified in some way.<sup>7</sup> Individual institutions are responsible for developing an Emergency Operations Plan to address specific details on how this will be accomplished.
    3. Become familiar with your institution’s specific policy regarding verification of a volunteer’s professional credentials (see, for example, the model volunteer protocol of the New York City Department of Health and Mental Hygiene).<sup>8</sup>
    4. Become familiar with your institution’s policy regarding informal caregivers, such as families, friends, or attendants employed by the patient’s family, who could provide basic care, such as feeding, bathing, or toileting. Institutions often restrict such input

because of liability concerns. Emergency preparedness committees should address these issues and may wish to formally address this potentially valuable input in the Emergency Operations Plan. (See Required Resources for Educators, Ahronheim JC, et al., 2009:30-38.)

- iii. Liability protections for volunteers.<sup>9</sup>
  1. Rationale: Unaffiliated providers or other volunteers are needed to augment care in a disaster or public health emergency. Laws at the federal and state level have been crafted to protect institutions, their employees, and unaffiliated volunteers from liability under these circumstances and to reassure persons who might otherwise be reluctant to volunteer because of legal risk concerns. Although state and federal law offers some protection for volunteers in ordinary circumstances (e.g., Volunteer Protection Act of 1997),<sup>10</sup> additional protections may be available to employees during a declared emergency.
  2. Legal protections take the form of indemnity or immunity.
    - a. Indemnity<sup>11</sup> is protection (such as a source of payment) for someone (or an entity) being sued, to be used for defense of the lawsuit and/or for any settlement or judgment that the person or entity must pay, i.e., insurance coverage for a provider who is sued for negligence (an unintentional error that might have harmed a patient).
    - b. Immunity<sup>12</sup> is an official protection or exemption from legal proceedings, i.e., if a provider is immune under law, a plaintiff cannot bring a lawsuit against that provider for an unintentional error that might have harmed a patient.
    - c. Laws in force during a declared emergency aim to protect individuals who act in good faith and may not immunize an act of "gross negligence,"<sup>13</sup> namely, one that exhibits reckless disregard for the safety and/or lives of others.
    - d. Liability protections in a disaster versus "Good Samaritan" laws: "Good Samaritan" laws are not specific to a disaster situation. All 50 states and the District of Columbia have Good Samaritan laws, which, though differing from each other in certain ways, generally provide liability protections for those who assist persons who are injured or in danger but who have come upon such persons by chance. This situation differs from a provider (including a

- volunteer) who has a preexisting duty to care for a patient and who is generally in a venue where optimal or adequate care is feasible.
- iv. The US Department of Health and Human Services has programs designed to promote effective volunteerism during emergencies. These include:
    1. The Medical Reserve Corps (MRC): community-based volunteer units that screen, train, and prepare volunteers to support local agencies in health care delivery, particularly during emergencies.<sup>4</sup>
    2. The Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP): a network of state-based programs that effectively facilitate the use of health professional volunteers in local, state, and federal emergency responses."<sup>4</sup>
    3. Disaster Medical Assistance Teams (DMATs): trained health professionals who can be mobilized in a declared emergency (although civilians, these workers become temporary, salaried employees when deployed).<sup>6</sup>
  - e. The HIPAA Privacy Rule and its application in a disaster or public health emergency
    - i. The Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule<sup>17</sup> forbids disclosure of protected health information without the patient's permission under most circumstances and continues to apply during a disaster. However, specific exceptions exist during the time of a declared emergency, when extraordinary obstacles exist:
    - ii. In a declared emergency, failure to comply with certain of the HIPAA Privacy Rule provisions may not result in sanctions or penalties, for example, failing to obtain a patient's permission to speak with interested parties such as family members. For further reading about the Privacy Rule and its application in a disaster, see Required Resources for Learners and Educators; Snyder 2012 and Supplemental Resources for Learners and Educators; Stevens GM, 2006; USDHHS 2014.
    - iii. Regardless of whether a disaster has been declared (that is, even in a nondeclared disaster situation), the HIPAA Privacy Rule permits disclosures for treatment purposes, to carry out public health operations, and to make certain disclosures to disaster relief organizations.<sup>18</sup> Furthermore, as a general rule, HIPAA permits disclosure for the public's health and for certain law enforcement functions, including locating a missing person, which could be especially relevant for vulnerable elderly during a disaster if cognitive impairment is present and others must make health care decisions for them.

- iv. Analogous state privacy laws exist in certain jurisdictions, prohibiting the disclosure of health-related information or permitting such disclosures in an emergency or in other special circumstances.
- f. Anticipating bioethical dilemmas
  - i. Distribution of limited resources and “ageism”
    1. According to the fundamental ethical principle of justice, health care resources should be distributed equitably.<sup>19</sup> Strict adherence to this principle would not permit restrictions based on certain characteristics, such as advanced age alone. Some argue that advanced age should limit access to certain life-saving interventions if they are scarce, as in a disaster or public health emergency. In this argument, such interventions should be provided preferentially to younger patients.
    2. For example, according to the “Fair Innings” argument,<sup>20</sup> everyone is entitled to “some ‘normal’ span of health,”<sup>21</sup> and the argument endeavors to level the playing field by giving all patients the opportunity to reach a normal life expectancy. Thus, a person who has not reached this “normal” span has not gotten a fair share, but anyone who has lived past his or her “normal” span is “living on borrowed time.”<sup>22</sup>
    3. Others contend that age alone should not be a factor in resource allocation.<sup>23</sup> Various arguments have been offered to support this opposing view, including quality of life considerations, comorbidities, specific prognosis, and considerations of biological versus chronological age (see Module 4-8). For further reading, see Required Resources for Learners and Required Resources for Educators (Ladin K, et al, 2011) and Supplemental Resources for Learners and Required Resources for Educators (Williams, 1997). Efforts to resolve this question in disaster preparation have been made, for example, through the application of clinical standards to the choice of who gets a ventilator (see Required Resources for Learners and Educators, NYS Workgroup on Ventilator Allocation, 2007).
  - ii. Disaster triage versus medical futility determinations
    1. Triage: In emergency situations such as a disaster, patients might be subject to the practice of triage, in which providers assign treatment priority, in a hierarchy, to patients most likely to survive. In effect, triage withholds treatment from those deemed unlikely to survive when resources are so limited that treatment

could not be provided as a practical matter. Although triage decisions are not necessarily protected from a liability standpoint,<sup>24</sup> organizations have developed consensus guidelines for triage and standards of medical care in these situations.<sup>25</sup>

2. Medical futility determinations: In a non-disaster situation, providers often apply the term “medical futility” when a patient is so sick or close to death that further treatment would be medically inappropriate. Providers do not feel it is ethical to unilaterally withhold or withdraw treatment without the patient’s or surrogate’s consent. Furthermore, with few exceptions,<sup>26</sup> state law does not allow such an action in the absence of the patient’s or surrogate’s request. The deliberation and process required for this very difficult determination on the part of providers would be seriously hampered in the situation of a disaster with mass casualties and limited resources. (See Required Resources for Learners and Required Resources for Educators, Fink S, 2009.)

## II. Lesson -Understanding Basic Concepts in Bioethics: a foundation for the extraordinary situation of a disaster

### a. Autonomy

- i. Definition: a form of personal liberty where the individual determines his or her own course of action in accordance with a plan chosen by himself or herself.<sup>27</sup> In the clinical setting, “patient autonomy” (also called patient “self-determination”) refers to the right of a person to make his or her own decisions about health care, usually whether to accept or reject a particular treatment.
- ii. Maintaining autonomy in patients who have lost decisional capacity. Patients who lose capacity do not lose the right to make health care decisions, which can be made for them by an authorized surrogate decision-maker (see “Surrogate decision-making” below).
- iii. Preserving the rights of adults who have never had capacity. People with moderate or severe intellectual and/or developmental disabilities who are now elderly may never have had the capacity to make health care decisions, and therefore, strictly speaking, have never had autonomy. However, they maintain important “liberty interests” such as well-being and freedom from unnecessary bodily invasion,<sup>28</sup> among other patients’ rights; health care decisions are made for them by others, with careful consideration to preserving these rights.
- iv. The challenge of maintaining patient autonomy in a disaster.

1. In a non-disaster situation, decision-making includes a deliberative process that involves careful consideration of prognosis, identifying an appropriate surrogate decision-maker when needed, and gathering loved ones to consider decisions together. In a disaster, the urgency of the situation, the overriding need for rapid triage decisions, the unavailability of surrogates, and the presence of providers who are unfamiliar with local protocols or regulations create new challenges. Furthermore, the public's health may take primacy over individual liberties in extraordinary situations.<sup>29</sup>
  2. All providers, including professionals who intend to volunteer in a disaster, should become familiar with triage standards and their rationale and the need to provide appropriate care, even if life-sustaining treatment is not available or desirable.
- b. Informed consent and decisional capacity
- i. Informed consent. When offering a treatment, a physician must provide enough information to the patient, in a way he or she can understand, for the patient to make a reasoned decision. The patient's decision, whether consent or refusal, must be voluntary. When someone else is authorized to make decisions on behalf of the patient, the informed consent process takes place between the physician and the person authorized to make the decision.
    1. Emergency exception to informed consent. In an emergency, when an immediate decision must be made to preserve the life or well-being of a patient who lacks capacity, the patient's consent is presumed unless there is clear evidence to the contrary, such as an available do-not-resuscitate (DNR) order (see below) and the clinician is not obliged to obtain consent before rendering treatment. This exception to the requirement for informed consent is particularly relevant in a disaster situation, for example, where mass casualties have occurred, time and information are limited, and triage is operative.
  - ii. Decisional capacity can be defined as the ability of a person to make his or her own health care decisions. The person should be able to understand the risks, benefits, and outcomes of a proposed treatment (or of its refusal) and the alternatives and should be able to communicate a stable decision.<sup>30</sup> (See Required Resources for Learners and Required Resources for Educators, Snyder, 2012:77; Supplemental

Resources for Learners and Supplemental Resources for Learners,  
Stanford Encyclopedia of Philosophy.)

1. Determining decisional capacity
  - a. Capacity assessment is a clinical determination that should be made by an experienced physician. (See Supplemental Resources for Learners and Required Resources for Educators, Ahronheim JC, et al, 2009:111.)
  - b. Capacity versus “competency.” Whereas capacity is a clinical determination, competence is a legal determination. A person is presumed to be legally “competent” unless determined otherwise in a court of law.
- c. Making health care decisions for others.
  - i. “Surrogate decision-making” as a general concept refers to a situation in which someone other than the patient makes a decision on behalf of the patient. This occurs when an adult lacks the ability to make health care decisions (either temporarily or permanently) and another adult, who has been provided information in an informed consent process, makes the decision for the patient. Traditionally, one or more adult family members (spouse or other close relative) or close friends are called upon to do this. A wide range of provisions exist in state laws governing who is legally authorized to make decisions for others, how the authorization is determined, the types of decisions that can be made by surrogates, and how a person’s previous wishes can be documented. It is important to become familiar with the law in your state regarding decision-making for other adults.
  - ii. Advance directives - directions given by an adult with capacity to be followed in the event that the person loses capacity in the future.
    1. Proxy appointment (also known as medical power of attorney, durable power of attorney for health care, and others) - An adult with capacity formally designates a person to make health care decisions in the event that the person loses capacity in the future. (See Supplemental Resources for Learners and Educators, American Bar Association, 2014).
    2. Living will (also called health care declaration) - A document in which a person with capacity provides instructions regarding what his or her wishes would be about medical treatments in the event of future loss of capacity. Typically, instructions are to avoid certain life-sustaining treatments in the event of incurable or life-

- threatening illness; however, living wills also provide the opportunity to express a wish to receive such treatments.
3. Informal advance directives. A person's wishes can be conveyed informally, for example in a conversation or a letter to a close family member or friend or with a health care provider directly, any of which could, ideally, be documented in the medical record. Although informal advance directives could raise challenges among relatives who disagree with a proposed course of action or contest the content of these conversations, disagreements are often resolved when providers consult closely with family members. In a disaster, when time is limited or formal advance directives inaccessible, informal advance directives might nonetheless play a valuable role.
- iii. A DNR authorization is not an advance directive per se, but reflects a person's specific wish to avoid restoration of heartbeat and breathing that has stopped. This wish is often declared in an advance directive; however, an actual order not to resuscitate is generally made after a clinician has deemed the person's prognosis to be limited, at which time a DNR order would be most relevant. (For further information, see Required Resources for Learners and Educators, Snyder L, 2012:84.)
  - iv. Standards of decision-making. When decisions are made for others, the following standards are used:
    1. A person's wishes if known;
    2. Substituted judgment - the surrogate decision-maker determines, based on his or her knowledge of the patient, what the patient's wishes regarding treatment would have been under the given circumstances;
    3. Best interests - if a surrogate is unable or does not feel able to judge what a patient would have wanted, the decision-maker determines what would have been in the "best interests" of the patient. The best interests standard is also applied for a patient who has never had the capacity to express wishes about treatments. In determining a patient's best interests, decision-makers generally evaluate whether the burdens of a proposed treatment would outweigh the benefits. Because "best interests" could be highly individual, the determination should be patient-centered. Examples from state law provide guidance.<sup>31</sup>

### III. Lesson -Serving elderly groups with differing needs

- a. Specific groups and their vulnerabilities in a disaster
  - i. Adults with cognitive impairments
    - 1. Loss of previous decisional capacity
      - a. Chronic (e.g., persons with moderate to severe dementia)
      - b. Potentially reversible (e.g., delirium, coma)
    - 2. Life-long absent or impaired decisional capacity (e.g., persons with moderate to severe intellectual or developmental disabilities who are now elderly).
  - ii. Frail elderly with multiple chronic illnesses and/or disabilities such as gait impairment and sensory deficits who may also require medical equipment, such as wheelchairs, oxygen, or special equipment for medication administration.
  - iii. Residents of nursing homes, assisted-living facilities, or other institutions, who may require higher levels of nursing or medical care in case of evacuation
  - iv. Adults with limited English proficiency
  - v. Lesbian, gay, bisexual, or transgender (LGBT) older adults
    - 1. The main factor that impacts LGBT older adults is: providers' and other caregivers' personal biases that may affect these elderly adults' care.
  - vi. Patients with advanced dementia, extreme frailty, or other life-threatening illness.
    - 1. Recognition of dementia as major cause of death (advanced dementia as a "terminal illness").
    - 2. Planning for palliative care approach in a disaster
      - a. Role for education of patients and families that palliative care is for physical and psychological symptoms (intention is not to hasten death).
      - b. Withholding or withdrawing life-sustaining treatment is different from assisted suicide/euthanasia("aid in dying").
      - c. Control of pain and suffering in a dying patient and the principle of "Double effect."
        - i. "Double effect" refers to an action intended to have a good effect (e.g., provision of strong medication to treat a bad symptom) but that could possibly have a second, unintended bad effect (e.g., hastening of death in someone already near death). In ethical reasoning, because the intended effect is considered

- to be a moral outcome, any unintended outcome could not be considered immoral.<sup>32</sup>
- ii. Caveat: It is important to note that any “hastening of death” is theoretical. When patients are near death, their condition might be so grave that symptom-controlling medications could further lower blood pressure or depress breathing. However, assuming the dose of medication was appropriate for the situation, it is not possible to know in these circumstances whether the medication or the dying process itself led to the moment of death.
- b. Federal legal authorities providing a basic foundation for emergency preparedness with regard to vulnerable populations. For a comprehensive overview on relevant statutes and related resources, see Required Resources for Learners (Centers for Disease Control and Prevention, 2012). Some examples include:
- i. The Pandemic and All-Hazards Preparedness Reauthorization Act of 2013 (PAHPRA) (42 USC § 201 et seq.) recognizes the particular needs of vulnerable individuals in the context of an emergency and therefore requires the Secretary of the Department of Health and Human Services to consider the public health and medical needs of at-risk individuals during a public health emergency.
    1. For further reading, see US Department of Health & Human Services. Pandemic and All-Hazards Preparedness Reauthorization Act - PHE.  
<http://www.phe.gov/Preparedness/legal/pahpa/Pages/pahpra.aspx>. Accessed April 30, 2015.
    2. Also see Association of State and Territorial Health Officials, Pandemic and All-Hazards Preparedness Act Fact Sheet,  
<http://astho.org/Programs/Preparedness/Public-Health-Emergency-Law/Emergency-Authority-and-Immunity-Toolkit/Pandemic-and-All-Hazards-Preparedness-Act-Fact-Sheet/>. Accessed November 4, 2014.
  - ii. Older Americans Act (OAA)
    1. The OAA requires that each individual State Unit on Aging (SUA) submit a plan detailing how the particular state will “coordinate activities and develop long-range emergency preparedness plans”<sup>33</sup> with regard to the needs of older individuals.

2. For further information, see CDC - Selected Federal Authorities - Emergency Preparedness for Older Adults - Aging, <http://www.cdc.gov/aging/emergency/legal/federal.htm>. Accessed April 28, 2015.
- iii. The Homeland Security Act of 2002, 6 USC 101 et seq. This statute provides for federal grants to be made to states to develop procedures for informing the public of evacuation plans before and during an evacuation (See 6 USC § 321a(A)). It includes guidance for the elderly and other people with special needs.
- iv. Federal acts that do not specifically apply to the elderly but that are important to be aware of in the event of a public health emergency include the following:
  1. The Robert T. Stafford Disaster Relief and Emergency Assistance Act of 1988, 42 USC § 5121-5207, which gives the federal government the legal authority to provide assistance to states during declared major disasters and emergencies.
  2. The Federal Emergency Management Agency's (FEMA's) National Response Framework (2008),<sup>34</sup> which addresses the management of terrorist attacks and catastrophic natural disasters.

### Suggested Learner Activities for Use in and Beyond the Classroom and Learner Assessment Strategies

- Discussion question: Allocation of scarce resources in a disaster.
  - Please take a look at one or more of the following resources regarding allocation methods. After browsing them, briefly summarize their allocation suggestions. Discuss the strengths and weaknesses of their approaches to resource allocation. How would their allocation methods specifically affect the elderly?
    - 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. New York State Department of Health website. [https://www.health.ny.gov/diseases/communicable/influenza/pandemic/ventilators/docs/ventilator\\_guidance.pdf](https://www.health.ny.gov/diseases/communicable/influenza/pandemic/ventilators/docs/ventilator_guidance.pdf). Published March 15, 2007. Accessed November 4, 2014.
    - Devereaux A, Dichter J, Christian M. Definitive care for the critically ill during a disaster: a framework for allocation of scarce resources in mass critical care. *Chest*. 2008;133(5):1S-66S.

- Powell T, Christ KC, Birkhead GS. Allocation of ventilators in a public health disaster. *Disaster Med Public Health Prep.* 2008 Mar;2(1):20-6.
- Case vignettes: basic principles and applications in a disaster.
  - Please use these vignettes for class discussion. Students should be able to answer the question(s) posed and understand the rationale for these questions. Terms such as medical power of attorney, health care agent/proxy, and durable power of attorney for health care can be used interchangeably in this exercise. Guidelines for faculty, when provided, are in italics.

### Case 1

Douglas is an 84-year-old retired mechanical engineer who has developed hip arthritis, which has become increasingly disabling. His daughter, Jennifer, has assisted him in care and accompanies him to his medical appointments. Douglas is otherwise in good health, but has become slightly forgetful and is hard of hearing. Jennifer has urged her father to get a hearing aid, but he refuses. She also urged him to execute an advance directive, and he decided to appoint Jennifer as his health care agent.

Jennifer thinks her father ought to have a hip replacement and takes him to see an orthopedic surgeon. She is worried, however, that this might be risky at his age. She has brought a copy of the advance directive to the office, which the physician reads over. Jennifer mentions her concerns, and also mentions quietly that her father has some memory loss. The physician nods, addressing Jennifer and not Douglas during the evaluation and explanation of the surgery. During the conversation, however, Douglas repeatedly tells the doctor to speak louder. "I may be deaf but I'm not stupid. If you want to fix my hip, I'd grateful to know in advance."

1. What bioethical principles are relevant in the informed consent process in this office encounter?

- *Answer: The principle of autonomy is relevant. Before the physician can even speak to Jennifer, he needs the explicit permission of the patient. Jennifer's authority to make decisions for her father exists only if he has insufficient capacity to make a specific decision himself, or unless he cedes his authority to Jennifer during this process. Memory loss does not mean a patient lacks the capacity to make a specific decision, as long as it is apparent that he understands the pertinent information and is able to communicate a stable decision. It is first important for the physician to determine if Douglas has capacity for this. He can begin by directly addressing the patient, enunciating, speaking in a volume the patient understands, talking directly into his ear, or even taking the time to write if necessary, and making sure he*

*understands the elements of the conversation. Hearing impairment not only interferes with communication between patient and physician, but also can be mistaken for dementia. Jennifer can certainly be involved in the discussion or the decision-making if Douglas wants her to be.*

2. Following recovery from successful surgery, Douglas sold his home and moved into a private apartment in an assisted-living facility where meals, exercise, and medical services are available on site. A year later, the city experiences a devastating flood, forcing evacuation of many people from their homes, including Douglas and other residents of his facility. Douglas is currently housed with others in a preestablished shelter in a nearby school, which is staffed by MRC personnel and a DMAT. Discuss problems that Douglas might face as an evacuee and delineate how good disaster planning could help him to cope until return to his place of residence.

### Case 2

Frances, a 68-year-old woman with metastatic cancer is rushed to the hospital after collapsing in the street. In the emergency room she is minimally responsive and brain imaging reveals she has a mass consistent with brain metastasis. Frances is given intravenous fluids while further information is sought. A medical chart reveals Frances had visited the emergency room a few weeks earlier where she received treatment for a sprained ankle. The record lists the phone number of an adult son who lives in Scotland. Frances is moved to a hospital floor for further treatment, but soon she continues to deteriorate and the nurse fears the patient is about to “arrest” and calls the physician. The physician has not yet had time to obtain authorization for a do-not-resuscitate (DNR) order, and tells the nurse she will be there right away. However, aware of Frances’ grave prognosis, the physician walks slowly to the patient’s bedside while responding to a call on her cell phone.

1. A patient with metastatic cancer, who is so sick that CPR becomes medically indicated, has a very low likelihood of surviving to discharge, despite CPR. Aside from the possibility that the phone call could be urgent, does the physician’s apparent intent to perform a “slow code” ethically justify her behavior in this circumstance? Why or why not?

- *Answer: Although the prognosis is grim, the physician must make an effort to quickly evaluate the patient’s deteriorating condition and prepare to initiate CPR if indicated, unless there is an instruction to the contrary, such as a DNR authorization. Decisions like this should not be made unilaterally because they violate the patient’s right of autonomy. In this case, limited information is available on which to base a decision, and the physician must first err on the side of attempting to preserve the patient’s life. Upon arriving at the bedside and especially after initiating CPR it will*

*soon become apparent whether the patient will respond at all. CPR does not need to be carried out indefinitely. The physician has an obligation to use her clinical judgment as to whether to initiate CPR and when to cease efforts if they do not work. If CPR were attempted and resulted in restoration of heartbeat and breathing, there would then be time to consider withdrawal of life sustaining treatment if appropriate, and to use any measures needed to ensure the patient's comfort.*

2. Many patients' living wills contain a statement such as, "I do not want to undergo CPR if I have a serious, terminal, or irreversible condition," which would easily describe Frances' situation. We do not yet know whether Frances ever executed a formal advance, such as a living will or proxy appointment, or even made statements about her wishes.

Comment on the difference between a DNR order and a formal advance directive as they might apply in this case.

- *Answer: Even if Frances had such an advance directive and it were available, decisions to perform CPR must be made immediately, whereas an advance directive has not only been written remotely, but as might be in this case, is usually not immediately available to guide the decision or relevant to the emergency situation. If an advance directive were available, it might help to guide a decision to authorize a DNR order, but as a practical matter, when CPR is indicated there is virtually no time for deliberation.*

Case 3.

Chris is a 74-year-old man who has suffered a head injury in a motor vehicle accident. He is unconscious but is considered to have a fairly good prognosis for recovery if surgery is performed. His domestic partner, Jacob, is authorized under the state's surrogate decision-making law to make health care decisions for Chris. Chris, who was previously married, has a 50-year-old daughter, Marcia, but Chris and Jacob have lived together for the past 20 years. Marcia has always resented her father's divorce and has not come to terms with the fact that her father is gay. She states that she has known her father "all his life," and feels that she, as next of kin, should be the one to make these decisions.

1. What ethical principle underlies a law that would give Jacob authority over Chris's adult daughter in this situation?

- *Answer: The ethical principal of autonomy underlies surrogate decision-making laws, as it underlies laws governing formal advance directives. A spouse or domestic partner is more likely to be aware of an adult patient's preferences in general than is a son, daughter, or other "next of kin," whose knowledge of the person is not the same as in the past or even now. Laws governing advance directive laws, moreover,*

*often explicitly authorize nonspousal domestic partners to make decisions for adults who have lost capacity.*

2. How might good disaster planning serve a patient such as Chris? Consider a hypothetical patient whose head injury occurred during a major earthquake. Consider multiple venues, such as a major metropolitan center, a small village with a community hospital, or a rural area.

Suggested sources:

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