

## **Saving or Leaving to Die**

### **Medical Ethics and Disaster**

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**Extreme conditions during disasters make it impossible to provide the individual medical care that victims require. It is sometimes necessary to make choices, to prioritize need, and sometimes even to leave victims to die. Following Sheri Fink's investigations in New Orleans after Hurricane Katrina, Frédérique Leichter-Flack shows how it is necessary to develop ethical preparation for disasters.**

“We are not as ready as we might have been,” concluded Anderson Cooper, a special reporter in New Orleans devastated by Hurricane Katrina in August 2005.<sup>1</sup> Should the main lesson drawn from a disaster be that we need to prepare for the next one? The scope of the disaster triggered by Katrina was the result of a grave absence of social protection, a problem that had grown and been neglected for years, and which, because of unforeseen events and because people were exposed, contributed to turning a natural phenomenon into a national disaster. The lessons drawn after the event must take that fact into account. But it was the failure of the Federal Government — and more particularly of the FEMA (the Federal Emergency Management Agency) — to manage the disaster and its fatal emergencies during the “long week of Katrina” that has been the main object of criticism.<sup>2</sup>

How can we draw useful lessons in terms of preparation for the future from that failure? The fundamental idea underlying “disaster preparedness” is that the next disaster may take on very different forms (natural disasters, industrial accidents, severe pandemics, or

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<sup>1</sup> This interview is mentioned in an article by Andrew Lakoff, “Pour qu’un désastre ne tourne pas à la catastrophe: jusqu’où sommes-nous prêts ?”, in *Esprit* (March 2008); “Before a Disaster Becomes a Catastrophe: The Limits of Preparedness”, *Understanding Katrina* (<http://understandingkatrina.ssrc.org/Lakoff/>), 11 June 2006.

<sup>2</sup> For an up-to-date description of the debate on the bad management of the Katrina disaster, see Romain Huret's recent *Katrina 2005. L'Ouragan, l'État et les pauvres aux États-Unis. (Katrina 2005. The Hurricane, the Government, and the Poor in the United States.)* Paris: EHESS Press, 2010.

bioterrorist attacks) but *will* take place and must be prepared for, whatever forms it takes. An approach that takes risk into account is not entirely to be left aside and the amount a society is ready to invest in preparedness is likely to depend on the probability of a disaster taking place in the more or less near future. Here, we will look at disaster management within the critical period marked by the general breakdown of all responsible services and the failure of all logistical order, which are the principle characteristics of the peak periods in any disaster.<sup>3</sup> Within this paradigm, the system of rescue and care is especially crucial in limiting the impact of disaster. How can lives be saved? Or rather, how can as many lives as possible be saved? After Katrina, and after the lawsuits instigated by the families of victims of Katrina, the state of Louisiana defined medical protocols concerning access to care in the case of disaster. Other states have done the same. Laws have been passed to protect health workers from prosecution for their actions in exceptional circumstances.<sup>4</sup> The H1N1 “swine” flu pandemic also reinforced the tendency to reason in terms of “disaster preparedness,” and the impetus for the worst-case planning that came out of confusion that reigned in hospitals in New Orleans during Hurricane Katrina has had repercussions across the country.

This outline of procedure opens an important ethical question. When we discuss disaster, we have to imagine extreme conditions — the disorganization of rescue services, the overcrowding of hospitals, the shortage of medical equipment and of competent personnel — conditions that make it impossible to provide medical care based on the ordinary principles of triage designed to offer victims the individual medical attention they require. Disaster recalls military triage on the battlefield. Should we decide ahead of time, according to categories defined in advance, who has priority access to the medical resources that in periods of disaster are necessarily inadequate? Should priority be given to the slightly injured who can be rapidly cared for? Or should medical resources — the time and efforts of health workers — be attributed to those whose chances of survival are sufficient to merit them, while those who have little chance of surviving are offered only palliative care and relief from pain? In other words, should we decide ahead of time — and stick to our decisions when the time comes, rather than letting our feelings or chance decide for us — who will be provided with the opportunity to survive when medical resources are insufficient? If so, then should criteria

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<sup>3</sup> On the history of the concept of disaster preparedness and its connection with the doctrine of national security in the United-States, see the Lakoff article mentioned above.

<sup>4</sup> See Sheri Fink, “Rationing Medical Care: Health Officials Struggle with Setting Standards,” on the *ProPublica* site (<http://www.propublica.org/article/rationing-medical-care-health-officials-struggle-with-setting-standards-122>).

other than medical prognosis be used for the triage of victims to be saved? With these perspectives in mind, it is not difficult to understand why the problem of the civil and legal liability of health workers needs to be solved beforehand.<sup>5</sup> Questions like these are frightening. They involve taboos (who has priority over whom?) that are fundamental to social cohesion. Is it necessary to ask these questions, and, if so, *how* should we ask them? Should they be left to experts, or should there be a democratic debate? What has a democratic society got to gain or lose with the ethical preparation of disaster?

The connection between the so-called lessons of Katrina and the definition of a protocol for disaster medicine based on the fiction of worst-case scenarios is not self-evident. Sheri Fink<sup>6</sup> decided to examine that connection and, in a long article that won the Pulitzer Prize for Investigative Reporting, described what happened in Memorial Hospital in New Orleans during the aftermath of Hurricane Katrina.<sup>7</sup> The Memorial Hospital affair is a particularly difficult one. Health workers were accused of having euthanized several patients in the last hours of the evacuation of the hospital, four days after the hurricane. In the legal investigation that followed, it emerged that some of the dead were elderly, in the terminal stages of serious diseases, and could not be moved. Other cases were less clear-cut. Were the morphine injections meant to relieve pain or to hasten the patients' deaths just before an evacuation that they would probably not survive? A grand jury, after hearing the forensic pathologists' report, declined to indict the doctors and nurses involved on second-degree murder charges — a verdict that coincided with public opinion, passionately interested in the tragic affair.

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<sup>5</sup> See in particular the arguments used in “Committee for Disaster Medicine Reform” (<http://www.cdmr.org/national.html>): “While the disaster created by Hurricane Katrina in New Orleans is one example of a catastrophic event, other areas of the country may suffer from earthquakes or other natural disasters. The potential for terrorist attack involving biological, chemical or nuclear attacks must be a part of national preparation. If any of these situations occur and massive casualties are suffered, physicians will face ‘battlefield’ triage conditions, and will be forced to ‘save those they can save,’ inherently putting other needy patients at additional, unintentional risk. The reality in such situation is that there will be numerous deaths, grieving families who may bring litigation and prosecutors who may investigate medical judgment during those disasters *without any real experience in disaster medicine*. If physicians and other medical personnel are to ‘answer the call’ to assist during these disasters in the future, additional protections are necessary – not merely to ‘protect’ the physicians, but to better serve future patients during such a crisis.” (About the Committee for Disaster Medicine Reform, Louisiana).

<sup>6</sup> Sheri Fink is a medically trained, American journalist and a fellow of the Harvard Humanitarian Initiative. She is the author of *War Hospital. A true story of surgery and survival*, a book about a hospital in Srebrenica during the siege, and of numerous inspiring articles on emergency medicine, humanitarian aid and public health, many of which have been published on the *Propublica.org* site, or broadcast the *PRI* program, *The World*.

<sup>7</sup> The investigation, “The Deadly Choices at Memorial,” was published in the *New York Times Magazine* and on *Propublica.org* (<http://www.propublica.org/article/the-deadly-choices-at-memorial-826/P1>).

“The Deadly Choices at Memorial” reconstitutes what happened during the four ghastly days in a flooded hospital, isolated from the rest of the world, and without electricity after Hurricane Katrina. The narrative is based on a series of passages from the testimony provided by witnesses and protagonists. To all appearances, the investigation begins where justice left off, searching the grey zones, getting still terrified witnesses to talk years after the events they lived through. However, the sensationalism (were patients euthanized in ghastly circumstances?) is merely a disguise. The journalist always names her sources and, when statements are contradicted by other sources, she says so. This is not merely a question of deontology. Her objective was not to find out the truth that justice had been unable to pin down. Her investigation concerns instead the mixture of perceptions and representations of the event in which the protagonists had been caught up — their inner monologues. What makes Sheri Frank's investigation exemplary and important is that her reconstitution of what happened is also a minute deconstruction of the manner in which the lived experience has been altered by the imagination.

The narrative uses every possible literary resource to evoke the atmosphere created by the disaster, complicated hour after hour by the continual aggravation of the situation: isolation and the feeling that they were forgotten, the fatigue and stress of the health workers who were on duty for days on end, the power cut that meant stifling heat, the absence of elevators (which meant that the patients had to be carried several floors down to the helipad to be evacuated), and of course, the absence of ventilators (which resulted in a number of deaths). The article does not require the reader to judge. In fact it does all it can to promote empathy and to encourage the suspension of our spontaneous reflex to judge, by considering all the various circumstances to be taken into account. Each decision made by the physicians is placed in its context — both its psychological context and the material circumstances, for example the order given by one of the head physicians to the exhausted nurses to neglect all treatment that was not of the first importance. The court, concerned only with the letter of the law, attempted to establish facts and did not take into account the constraints that weighed on him under particular circumstances.<sup>8</sup> The reporter's investigation, on the other hand, examines the psychological and moral processes at work. The narrative does what it can to take the

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<sup>8</sup> Euthanasia is illegal in the state of Louisiana and the legal investigation intended only to establish whether or not there had been intent to kill. The exceptional circumstances, the particular constraints connected to the context, and the complexity of the dilemmas that the medical personnel had to face were not taken into consideration. What had to be decided — and the coroner decided almost alone — was whether the drugs found in the bodies of the victims and responsible for their deaths were the result of medical prescriptions for pain relief (“comfort care”), or proof of an intention to hasten death (even in the form of “mercy killing”).

reader inside the heads of those who, sincerely it seems, believed that what they had decided to do was the most humane decision possible — thus contributing to place the issue on the ethical plane.

The reporter thus quotes a doctor who says he ordered an increase in the dose of morphine in a patient's IV with the avowed aim of hastening her death and thus being able to redirect the nurses retained at her bedside to other tasks.<sup>9</sup> ““To me, it was a no-brainer, and to this day I don't feel bad about what I did,' he told me. 'I gave her medicine so I could get rid of her faster, get the nurses off the floor.’” The patient he is talking about was a very old lady, in the terminal phase of cancer, already unconscious after being given sedatives and expected to live no more than a day or two, a case that did not raise the same questions as those which were examined by the judges. The doctor expresses three ideas which emerge again later in the article: the systemic connection, through the use of morphine, between “relieving pain” and “hastening death;” the pertinence in medical decision-making of the utilitarian criteria of optimal use of available resources; and the powerful idea of “mercy killing” which here for the first time goes with the explicit formulation of a dilemma which would become more and more acute in the following hours: what is more humane, to hasten death or to abandon patients that cannot be saved?

The trial was only concerned with the first question, i.e. the difference between “comfort care” and “hastening death” on which the forensic expert was asked to make a statement. But the other two points also need to be examined, because they form the basis of any future use of the disaster as an example in the preparation of other disasters: how did the “mercy killing” dilemma (euthanasia or leaving patients to die without care) emerge? And on what principles were decisions to allocate available resources based? The disaster narrative draws the reader's attention to these two questions and opens up the issue once again.

### **The Construction of the Idea of “Mercy Killing”**

The article shows how the idea of “mercy killing” emerged progressively, and frighteningly, in the exchanges between doctors and nurses about certain patients whose condition had deteriorated considerably. “Help was coming too slowly. There were too many

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<sup>9</sup> He spoke with relative freedom as he had not himself been troubled by the law, since he was no longer on the scene when the hospital was finally evacuated, that is when the final, supposedly lethal, injections (with which the trial was concerned) were administered.

people who needed to leave and weren't going to make it, he said, describing for me his thinking at the time. It was a desperate situation and he saw only two choices: quicken their deaths or abandon them. 'It was actually to the point where you were considering that you couldn't just leave them; the humane thing would be to put 'em out.'" From page to page the way the dilemma is formulated changes, at least where the patients in the worst shape are concerned — the ones who had been assigned "3s", were lying on the floor, and were slated to be evacuated last. When the Police announced on the fourth day that everyone had to be out of the hospital by 5 p.m. because of civil unrest in New Orleans, the pressure of security tipped the balance: "the plan is not to leave any living patient behind." The testimony of one doctor shows the role played in the imagination by the fear of what would happen if patients were left behind after the departure of the Police. "He expected that the people firing guns into the chaos of New Orleans — 'the animals,' he called them — would storm the hospital, looking for drugs after everyone else was gone. 'I figured, What would they do, these crazy black people who think they've been oppressed for all these years by white people? I mean if they're capable of shooting at somebody, why are they not capable of raping them or, or, you know, dismembering them? What's to prevent them from doing things like that?'"<sup>10</sup> Is this a reconstruction after the fact for the purposes of self-justification or are these really the thoughts he had at the time? ""We were abandoned by the government, [...] and clearly nobody was going to take care of these people in their dying moments." And another nurse concluded, "We did the best we could do. It was the right thing to do under the circumstances."

At no time, it seems, was the possibility of patients pulling through without treatment considered. There was no place for a miracle, chance, or fate, and this also meant that the doctors' sense of responsibility made them feel that it was their duty do something and to control the outcome. We still do not know what factors tipped the balance in favor of mercy killing. Was it the argument of pain — the fear of leaving patients behind in pain and without care? But then isn't that argument always more powerful than any reasoning or moral objection? Or was it shame at escaping oneself and leaving living patients behind? Was that,

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<sup>10</sup> The race issue runs through the whole investigation. It is unobtrusive enough not to monopolize the reader's attention but its role is nevertheless important.

for a doctor, an unbearable vision, and one that was incompatible with the demands of medical ethics?<sup>11</sup>

The question seems to have come to a narrow alternative: a choice between two negatives. Is it more humane to hasten the death of patients or to leave them without care, in the sweltering heat, in pain and alone? Is this reading of the situation the effect of a case of *force majeure* or is it the result of panic, of a psychological bubble that might and should be analyzed. The forensic pathologist, who knew that the verdict of the trial for euthanasia largely depended on the results of his analyses of the corpses, told the reporter how he had hesitated before making a statement. He seems to concede that what happened was inevitable when he tells the reporter that in a situation like this he would at least have tried to rescue the obese patient, whose weight (he was too heavy to be carried to the helipad) and not health, impeded evacuation. Before drawing lessons for future disasters and deciding ahead of time which patients should be left behind when everyone cannot be saved, it is perhaps necessary to analyze the role of the imagination in decision-making in a disaster situation.

By reconstituting the way the “disaster” was seen by those who lived through it, the way it was progressively structured mentally around the ethical dilemma, the article deconstructs the manner in which a point of no return was reached. The narrative explores the genealogy of the dilemma with two coexisting narrative lines. One helps us see the situation from inside, as if we were one of the doctors confronted with these dreadful choices. The author uses all the resources of fiction to produce this effect and promote empathy. In another more modest but firm narrative line, she stands back from the disaster and examines the way it was constructed step by step, and then deconstructs the speculative or ethical bubbles. We are asked to notice, for example, the tragic errors committed because of uncertainty,<sup>12</sup> and we are warned each time a red line is crossed, even for the best of reasons and probably with entire sincerity.<sup>13</sup> One of those ethical red lines crossed under the pressure of the “disaster”, well before the incriminated actions, concerns the protocol of triage.

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<sup>11</sup> Sophie Crozier, a neurologist and an expert in medical ethics, inspired these arguments. Let me thank her here for her reading of the manuscript of this article.

<sup>12</sup> Thus, for example, when the Coast-Guard’s offer to evacuate more patients was rejected by the exhausted health workers: “It was dark when the last of the Memorial patients who had been chosen for immediate evacuation were finally gone. Later that night, the Coast Guard offered to evacuate more patients, but those in charge at Memorial declined. The helipad had minimal lighting and no guard rail, and the staff needed rest.”

<sup>13</sup> Sincerity is uncertain however, since the testimony was given after the fact — years after the event.

## **The Criteria for Triage: Who Should be Saved If Everyone Can't Be?**

When, on the first day, the first triage had to be performed very quickly in order to decide which patients would leave with the first available helicopters, it was decided that patients with “do not resuscitate orders” would be evacuated last. At this point, the journalist speaks in her own voice insisting that there has been an interpretative shift.

“A D.N.R. order is signed by a doctor, almost always with the informed consent of a patient or health care proxy, and means one thing: A patient whose heartbeat or breathing has stopped should not be revived. [...] But [X] had a different understanding, he told me not long ago. He said that patients with D.N.R. orders had terminal or irreversible conditions, and at Memorial he believed they should go last because they would have had the ‘least to lose’ compared with other patients if calamity struck. Other doctors at the meeting agreed with [X]’s plan. [Y], a neuroradiologist, told me he thought that patients who did not wish their lives to be prolonged by extraordinary measures wouldn’t want to be saved at the expense of others — though there was nothing in the orders that stated this. At the time, those attending the meeting didn’t see it as a momentous decision, since rescuers were expected to evacuate everyone in the hospital within a few hours.”

Thus the D.N.R. patients, on the basis of a misunderstanding, are set aside as not having priority for evacuation. The decision was made without taking individual short- and medium-term prognosis into consideration. During the second stage of triage for the improvised evacuation in the days that followed, labels with the numbers 1, 2, and 3 were stuck to the clothing of the patients lying on the floor. “The importance of reassessing each person is easy to forget once a ranking is assigned.” The author’s tone demonstrates more empathy as she points out the continual reversal of priority between the seriously injured and the slightly injured, but also the dangers of rigid ranking. In the particular conditions of a disaster, this ranking will not be reconsidered on the basis of changes either in the patient’s condition (and, of course, it assumes that the prognosis was correct in the first place) or of the availability of evacuation resources. Thus, on the basis of a series of misunderstandings, a protocol for civil triage (according to which patients who were in fairly good health would wait) turned imperceptibly at first into a military triage (which would reserve the available medical means for those who had the greatest chance of recuperating and thus create a category of *morituri* to whom only palliative care would be given).

Should the idea of disaster be considered a facile argument that uses the idea of a state of emergency to cancel all scruples? From outside, far from the scene of the emergency, it is impossible to criticize the decisions made by doctors whose sincerity, altruism, and devotion to their patients are not in question. But even from within the narrative, a critique of the idea of disaster emerges from time to time when certain witnesses express their horror as



they realize that the new norms of medical ethics implicitly at work obliterate the chances of survival of their loved ones. The fear expressed by one woman who tried (in vain) to change the D.N.R. order for her mother when she realized that it implied that she would not be evacuated quickly, is just one example. Another is the case of a man who managed to get to the flooded hospital in a makeshift boat in order to save his mother, who was hospitalized there, only to discover that his mother's IV had been taken away on a doctor's orders although she needed it to keep hydrated. This was one of the results of a protocol designed to limit non-vital medical interventions. "When he asked a Memorial administrator why, the administrator told him that the hospital was in survival mode, not treating mode. Furious, Mark LeBlanc asked, 'Do you just flip a switch and you're not a hospital anymore?'" That criticism was, of course, unfair but it does draw attention to the ethical scandal that is all but forgotten due to the "necessary" nature ("survival" and "state of emergency" are the key words) of the decisions made.

All these factors open the debate on preparedness that the incriminated doctors had attempted to close. Should the sickest patients be evacuated last? Which system of triage should be adopted? How can we be sure that regular reassessment of resources and of the patients' conditions will maintain the necessary equity? And, above all, how can we avoid the closing of the debate that the very idea of disaster induces?

Ethical guidelines for medical intervention adapted to disaster situations are being prepared for extreme conditions and this is probably the best possible way to avoid the unfair treatment that is inherent in the management of emergencies on the basis of feelings, influence, or simple chance. If everyone cannot be saved, we need rules accepted by everyone and applicable everywhere to help decide whom to save first. Resorting to the idea of disaster as an exceptional state of emergency may be the only way to guarantee that health workers will answer the call and it is a way of protecting them both from possible lawsuits later on and from the weight of a responsibility too great for any individual to bear alone. Does that imply that the health care rationing that usually goes with disaster situations is inevitable?

Two other reports written by Sheri Fink examine the question on the basis of two case studies that present diametrically opposite choices. The first report concerns Haiti in the

days following the earthquake in January 2010.<sup>14</sup> Sheri Fink, reporting from an American field hospital set up by humanitarian aid in Haiti, draws our attention to the case of a young woman with a chronic heart condition that causes breathing difficulties. The head physician in charge of the hospital decided, in the context of short supplies connected with the disaster, that it would be better to keep the little oxygen they had for the many victims of the earthquake who each needed a little to get better rather than for a single person who would always need it. “Providing care for one patient may deny it for others.” Without having seen her, says the reporter, the doctor refused to give her the oxygen she needed and had her transferred to another hospital, which was known to lack oxygen and where she would probably die for lack of treatment. The story, miraculously, has a happy end. When the ambulance arrived another medical team found some oxygen, the young woman survived and her condition was stabilized to such an extent that she no longer requires assistance breathing. It is uncertain whether there is a moral to be drawn from this report as to the difficult choices faced by emergency doctors in Haiti, but if it is necessary to draw one nevertheless, it might well be this: before thinking about rationing resources in terms of a dilemma (who will live and who will die), we must never forget to ask how to increase the stock of available resources.

And that is precisely what the other article illustrates in the context of the H1N1 flu pandemic in India last year.<sup>15</sup> More and more sick babies with difficulty breathing were filling the pediatrics ward that served as an H1N1 centre. There were not enough ventilators. Triage guidelines in disaster situations recommend reserving available equipment for the babies whose chances of survival are the greatest. Sheri Fink talked to the doctor who told her how the dilemma presented itself. A very sick baby with little chance of surviving was brought to her and there was just one ventilator free in the hospital. She hesitated to give it to him because she imagined what would happen if other babies arrived in less desperate conditions that she would not be able to treat. She nevertheless decided to put the baby on the last available ventilator. Just as she had thought, two more babies arrived in the following hours. Their prognosis was better than the first baby's but they would not survive unless they were given oxygen. Under pressure, the doctor tried to put together a makeshift system to replace the missing ventilators. The system might work or it might kill the babies. In fact, it saved the

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<sup>14</sup> “Doctors Face Ethical Decisions in Haiti,” on PRI’s *The World*: <http://www.theworld.org/2010/02/23/doctors-face-ethical-decisions-in-haiti/>

<sup>15</sup> “India: Rationing in Disasters,” on PRI’s *The World*: <http://rationinghealth.org/india-rationing-in-disasters>.

babies' lives. In the following weeks, the makeshift system, dubbed "bubbles of hope" was used on numerous babies and saved many lives. As to the first baby, whose case seemed desperate, he too finally recovered. The moral of the story, which the Indian doctor drew explicitly this time, was that it is of crucial importance to leave space for the creative imagination in disaster situations.

### **Imagination in disaster situations**

Should the happy end of the Indian story convince us of the importance of "maintaining flexibility" even in disaster situations? By preparing ourselves too carefully to act in the exceptional circumstances we face in disasters, are we closing ourselves off from possibilities we cannot foresee? Are we preventing miracles from taking place? How can we leave a space open for improvisation, creativity, and luck, a space for feelings that does not work against the imperatives of justice and equality?

The role of the imagination in disaster situations is what is under question here. It is the imagination that allows us to find unexpected solutions to problems, thus postponing the special ethical regime that we must resign ourselves to during a disaster. But it is also the imagination that hastens our recourse to a state of emergency by urging us to picture even worse situations than the reality before our eyes. To what level of disaster do we have to fall before the new practices are considered morally acceptable?<sup>16</sup> The question of degrees of disaster is of fundamental importance. Yet how can we avoid the concept's being misused? Is there not some comfort in the concept of disaster, a use of the concept that is closed in on itself, and that only serves to justify ethical decisions which would otherwise be impossible to accept? A disaster is not just another degree that can be clearly and objectively identified, but is rather the final stage in a continuum. Perhaps a disaster is the artificial exaggeration of more ordinary situations in which the choices of triage, of distribution and of rationing of medical resources already exist, but are not discussed publicly.

Paradoxically, one of the positive upshots of bringing the debate on medical protocols and ethics in disaster situations before the public eye is that, instead of its being left to experts, the general public has gained in understanding of what it means to ration health

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<sup>16</sup> This is one of the questions asked by the doctor heading the Louisiana committee for the establishment of ethical guidelines for doctors in disaster situations. See <http://www.propublica.org/article/louisiana-professionals-drafting-disaster-critical-care-access-guidelines>.

resources and has been made to feel at least partially responsible for the criteria on which decisions of an ethical nature are based. Although it is not easy to represent the stakes involved (which the doctors themselves find terrifying) for the general public, it is only by taking part in a discussion beforehand that the public will accept without rebelling the principle of triage. This means that society must engage in the debate on the criteria on which triage is based.

Experts, whether doctors, policy planners or ethicists are not the best persons to decide for the general public on the way it wishes to be treated if there is a disaster. The general public will have to feel that the values underlying the principles of triage and the standards of care in a disaster situation are its own if it is to recognize them as legitimate. The example of an exercise carried out in the United States within the framework of the preparation for an H1N1 pandemic shows that the criteria retained for triage protocols by experts and the general public are not always identical.<sup>17</sup> The general public prefers a maximum number of lives saved, accepts a drop in the quality of care as the probably inevitable consequence of that objective, and favors the idea of a coherent triage protocol rather than one based on chance. It recognizes the crucial importance of the criterion of chances of survival in the ranking of access to medical resources and trusts medical judgement in the evaluation of prognosis. It mostly rejects the criterion of social usefulness (except where health workers, whose priority is accepted, are concerned). And it is particularly concerned about fairness and non-discrimination, especially in the case of the most vulnerable groups.

Ways of seeing matter. Preparedness is not merely a question for experts. Because of the ethical stakes, it is a question that affects the contract of mutual trust that citizens of a democracy underwrite — confidence in each other and in those to whom they entrust their

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<sup>17</sup> The criterion of the number years of life saved (the age of victims) is not really relevant, and is only agreed to when the other criteria are respected as well. See the report “Public Engagement Project on Medical Service Prioritization During an Influenza Pandemic,” (September 2009), ([http://s3.amazonaws.com/propublica/assets/docs/seattle\\_public\\_engagement\\_project\\_final\\_sept2009.pdf](http://s3.amazonaws.com/propublica/assets/docs/seattle_public_engagement_project_final_sept2009.pdf)) and the review in *Journal of Participatory Medicine* (<http://www.jopm.org/evidence/case-studies/2010/12/14/health-care-decisions-in-disasters-engaging-the-public-on-medical-service-prioritization-during-a-severe-influenza-pandemic/>): “The limited guidance that exists has not been directly informed by public values and opinions. To address this gap, Public Health – Seattle & King County (PHSKC) engaged the public to better understand its values and priorities regarding the delivery of medical services and how those services will be allocated during a severe influenza pandemic. By involving the public, PHSKC sought to inform the policies, plans, and guidelines about medical service prioritization developed in Washington State based on actual values and ethical perspectives held by the people who live in the region”.

lives. And the preservation of that trust, for the medium-term management of a disaster, is perhaps just as important as the short-term efficiency of the rescue service. What remains to be decided, however, is whether preparedness, from this point of view, really does more good than harm. Of course, this sort of debate will allow us to be “ready and fair” when the time comes, but there is a social price to be paid and possibly negative effects due to the way it assigns value to lives. These risks are probably part of the reason why public debates on the criteria underlying the rationing of health resources are so rare and why the discussion is still largely left to experts. Finally, we might also ask if the imagination, which, as we have seen, plays such an important role in disaster situations, can really be activated at will during simulations designed to engage the general public’s reflexes and ethical perceptions. Feelings in particular are a key factor in behavior during disasters and yet they can play both ways. Can they really be anticipated? Should they not be defined instead as precisely that which cannot be foreseen — connected to the particular rather than the general case?

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