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Hurricane Katrina and the Legal and Bioethical Implications of Involuntary Euthanasia as a Component of Disaster Management in Extreme Emergency Situations

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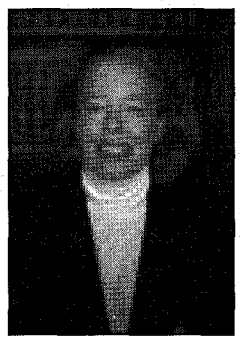

The delivery of health care in extreme disaster situations presents the worst case scenarios and places the most strain on our health care practitioners and systems. This is apparent even to individuals who are not involved in the delivery of health care. Anyone with a television can recall the media images of people jumping to their deaths and racing from the collapsing Twin Towers in New York after the terrorist attacks on September 11th, as well as the corpses floating through the water while panicked individuals tried to signal passing helicopters from flooded rooftops after Hurricane Katrina in New Orleans. Even as we live in the wake of these events, we currently cope with the medical disaster involving the H1N1 flu pandemic. Within the context of the delivery of medical care, the question that inevitably arises during these events is should, or can, standards and practices other than those which have been legally and ethically established be applied given these extreme circumstances? The need to address this issue is obvious given the reality that it will continue to be raised as we try to cope with and plan for the medical fallout from future disasters.

One of the most compelling and ultimately troubling examples of an alleged divergence from accepted legal and bioethical standards under disaster circumstances arose out of the many allegations of euthanasia at Memorial Medical Center (Memorial) in New Orleans against a physician and two nurses during the Hurricane Katrina disaster. Dr. Anna Pou, a respected head and neck surgeon, remained at the hospital throughout the ordeal although she was initially given the opportunity to evacuate, and treated the patients from Monday, August 29, 2005, until all remaining living patients were evacuated on Thursday, September 1. Dr. Pou and

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other Memorial staff members worked under the most extreme and medically compromised circumstances throughout this period of time, such as flooding that caused the failure of electricity, the use of back-up generators and plumbing, and in heat exceeding 100 degrees. At the time of Hurricane Katrina, Memorial leased the seventh floor of its facility to LifeCare Hospitals (LifeCare) which operated a long-term acute care unit. As the physician on call for the unit did not show up during the crisis, Dr. Pou and other staff members cared for these patients. These patients had chronic medical conditions, but were not thought to be in imminent danger of death; the LifeCare floor was not a hospice.

The evacuation process was chaotic, poor, at times lacked governmental and private response, and was attempted under a breakdown in communication systems as the result of the power outage. The process of evacuating most patients involved a forty-five minute process which included passing the patient through a three by three foot hole in order to access a helipad. By early Thursday morning, while the staff was exhausted beyond belief, an announcement was made that the hospital would be completely evacuated that day. Nine patients remained on the LifeCare floor. According to an affidavit filed by the Louisiana Attorney General's Office, Dr. Pou made statements that she was going to administer lethal doses to these patients, asked for and received narcotics and syringes which could cause death, and was seen entering and leaving these patients rooms with two nurses. One year later, Dr. Pou was arrested and charged with second degree murder for allegedly causing the death of four of the nine patients. These allegations generated intense outrage and public criticism in New Orleans, which was still struggling in an attempt to recover from Katrina. Dr. Pou was seen by the public and echoed in the press as someone who persevered in the face of disaster while the government—on the city, state and federal levels—failed to respond by abandoning not only the general population but its most helpless citizens, the medically infirm, to fend for themselves. When the allegations were later presented before a grand jury, no indictments were returned.

Since the allegations, Dr. Pou has been steadfast in maintaining her innocence and has asserted that the injections she gave were a legally and ethically justifiable attempt to treat the patients' pain and anxiety, that is, to provide "comfort care." She denies that they were provided with the intent to cause death, intent to cause death being a necessary element to prove the charge of murder as well as to fit within the definition of euthanasia. A close examination of the witness statements contained within the affidavit filed by the Attorney General's Office, however, shows apparently inculpatory statements made by Dr. Pou during the disaster and establishes an incriminating sequence of events leading up to the injections and subsequent deaths of the patients. In conjunction with the expert opinions

(obtained by the Attorney General's Office) in the affidavit as to the cause of death, the affidavit presents a compelling circumstantial case contrary to Dr. Pou's statements.[1] With the lack of a criminal trial, along with Dr. Pou's ongoing denial of any intent to cause the deaths of the patients, the truth is unlikely ever to be known.

This case has generated a substantial amount of ongoing controversy over the intersecting ethical, legal and medical issues it has raised. End of life issues, and in particular, end of life decision-making, have been the subject of ongoing debate and litigation in our society. The allegations surrounding what happened to the LifeCare patients present an opportunity to examine these issues within the context of providing medical care in disaster situations. Ultimately, the question becomes not only whether Dr. Pou intended to kill or euthanize the patients, but, if she did, were her actions consistent with the ethical and legal morals our country has developed regarding end of life issues? Further, if her actions were not, do the extreme circumstances justify a deviation from these standards?

As a society, we live within certain ethical and legal constraints that reflect society's ethics and values. The prohibition against intentional killing in the criminal codes of the states is one of the most obvious examples of law reflecting ethics or values. Over the last half century, we have experienced reliance on the law through the use of the courts not only to resolve disputes concerning the propriety of medical care, but also to resolve ethical issues concerning medical care. The result has been the development of a body of law which reflects the rights to freedom and liberty established by the United States Constitution. This body of law reflects the trend of deviation from medical paternalism, where physicians were, in effect, vested with the unilateral authority to make decisions regarding medical care on behalf of the patient with little or no input from the patient or even a surrogate and with minimal oversight or accountability, towards one of patient autonomy and self-determination in making medical decisions.

Despite this historical deference to physicians, early common law established the constitutional right to bodily integrity.[2] Justice Cardozo, in the 1914 case of *Schloendorff v. Society of New York Hospital*, applied this

1. Aff. of Virginia B. Rider, State of Louisiana v. Anna M. Pou, et. al, No. 59-2652 (La. Dist. Ct), *at* http://news.findlaw.com/nytimes/docs/katrina/lapoui706wrnt.html [hereinafter referred to as Affidavit]; *see also* Sheri Fink, M.D., *The Deadly Choices at Memorial*, N.Y. TIMES MAG., Aug. 30, 2009 (discussing the conditions and the events leading up to the allegations of euthanasia against Memorial and quoting an additional physician as having admitted to intentionally hastening the demise of at least one patient).

2. Union Pac. R.R. Co. v. Botsford, 141 U.S. 250-51 (1891), (recognizing that "(n)o right is held more sacred, or is more carefully guarded by the common law, than the right of every individual to be in possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law").

right to be free of bodily intrusions to the requirement that physicians and medical personnel obtain patient consent to perform medical procedures.[3] In 1972, a federal court in the pivotal case of *Canterbury v. Spence*,[4] expanded this right to include the right to informed consent, reasoning that without informed consent, no meaningful and intelligent consent can be given.[5] With this ruling, it became clear that medical decisions were no longer the exclusive domain of doctors - patients began to expect control over these decisions. Through their decisions, then, the courts began to reflect this shift.

One of the first cases to attract wide public attention and media coverage for addressing patients' rights at the end of life was *In re Quinlan*.[6] In this case, the New Jersey Supreme Court held that Ms. Quinlan, who was in a persistent vegetative state, had the right to have her respirator removed even if the likely result would be death. Ms. Quinlan's physicians objected that the removal would not conform to medical practices, standards and traditions.[7] The court found the patients wishes to be predominant and the physicians' interests less compelling than the patient's privacy right to refuse treatment.[8] In addition, the court rejected the concept that a ruling against the physicians would amount to an inappropriate intrusion of law into medicine and found that the court was not precluded from reexamining underlying human values and rights when deciding clearly justiciable matters.[9] Later, in the 1985 case *In re Conroy*,[10] the same court addressed the question of whether a nasogastric feeding tube could be removed from an incompetent nursing home patient with irreversible mental and physical conditions.[11] Unlike its privacy approach in *Quinlan*, the court based its decision on the common right to self-determination and informed consent, and recognized that these rights, which encompass the right to refuse treatment, outweigh any countervailing state interests.[12]

In the landmark case *Cruzan v. Dep't of Health,* based upon facts similar to *Quinlan* and *Conroy*, the United States Supreme Court affirmed these

3. Schloendorff v. Soc'y of N.Y. Hosp., 105 N.E. 92 (N.Y. 1914) (J. Cardozo) (articulating the doctrine of informed consent: "Every human being of adult years and sound mind has the right to determine what shall be done with his own body; and a surgeon who performs an operation without his patients' consent commits an assault, for which he is liable in damages.").

4. Canterbury v. Spence, 464 F.2d 772 (D.C. Cir. 1972).

5. *Id.*

6. *In re* Quinlan, 70 N.J. 10, 355 A.2d 647 (1976).

7. *Id.* at 665.

8. *Id.* at 663-664.

9. *Id.* at 665.

10. *In re* Conroy, 98 N.J. 321 (N.J. 1985).

11. Cruzan v. Dep't of Health, 497 U.S. 261, 271 (1990) (citing *Conroy*, 98 N.J. 321).

12. *Cruzan*, 497 U.S. at 271.

rights in 1985.[13] The Court found that the right to informed consent includes the right to refuse consent and recognized that individuals have a constitutionally based liberty interest in refusing unwanted medical treatment.[14] The Court further addressed concerns raised regarding the issue of a surrogate acting on behalf of an incompetent patient to withdraw life-sustaining treatment and found that the state may protect such patients by requiring clear and convincing proof the patient's wishes regarding treatment. The *Cruzan* court, as well as several lower courts, favored the use of a "substituted judgment" standard as opposed to a "best interests" standard. The former requires the surrogate to base decisions on what the patient's treatment preferences would be, as opposed to the latter, which allows the surrogate to make decisions based upon what he believes would be in the best interests of the patient.[15] Additionally, the "best interests" standard would allow surrogates to make their own subjective determination of the acceptability of the patient's quality of life when making a decision to whether to withdraw treatment.[16] According to this body of case law, then, the "best interests" standard would be inconsistent with the principles of self-determination, particularly as they apply to end of life decisions.

Modern medical ethics codes directly reflect these principles. In its policy regarding informed consent, the American Medical Association (AMA) indicates that, "(t)he patient should make his or her own determination on treatment."[17] In its ethical policy regarding withholding or withdrawing life-sustaining treatment, the AMA provides that the principle of patient autonomy requires that physicians respect a patient's decision to forego life-sustaining treatment even when it conflicts with a physician's duty to sustain life and relieve suffering.[18]

Dr. Pou was alleged to have intentionally caused the deaths of the remaining LifeCare patients. If she provided the injections with the intent to cause their death, it would amount to murder. Describing the allegations as euthanasia is not exculpatory. By definition, both murder and euthanasia involve intentional acts to cause death. The distinction is that euthanasia is usually done with the motive to relieve pain or suffering. Nevertheless, the

13. *Id.*
14. *Id.* at 269.
15. *Id.* at 280.
16. *Id.* at 276.
17. AM. MEDICAL ASSN., CODE OF MEDICAL ETHICS 8.08 (2006), *available at* http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion808.shtml ("Informed Consent").
18. AM. MEDICAL ASSN., CODE OF MEDICAL ETHICS 2.20 (1996), *available at* http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion220.shtml ("Withholding or Withdrawing Life-Sustaining Treatment").

AMA prohibits euthanasia as inconsistent with the physician's role as a healer.[19] The courts have neither recognized a right to euthanasia, nor recognized it as a defense to intentional killing regardless of a motive to relieve suffering. Furthermore, the acts as alleged would amount to involuntary euthanasia, which runs directly counter to the rights to informed consent and patient self-determination.

Physicians inevitably fear any prosecution concerning the administration of medical care, particularly in situations involving prescribing or administering narcotics for pain relief. However, the courts, legislators, and the AMA have recognized that the "principle of double-effect" as protecting physicians where the intent of the medical treatment was not to cause death, but to provide palliative care. The distinction lies in the difference between motive and intent which may have been lost in the aftermath of the tragedy involving the LifeCare patients. The focus on Dr. Pou's altruism in staying at the hospital to treat the patients may have overshadowed the real possibility that the injections were given with the intent to end the patients' lives. While she may have thought this was the most humane alternative under these clearly disastrous circumstances, a "good" or merciful motive will not ethically or legally justify intentional killing.

Providing medical care in disasters and emergencies inevitably compromises the principles surrounding patient autonomy. Often there are limited resources and little or no time for the consideration and reflection that is available under ordinary circumstances. This makes planning for future disasters and developing frameworks and paradigms for the medical response to these situations, which address, and are consistent, with established ethical and legal principles to the greatest extent possible, more, and not less, important. Incorporating certain rights into these plans, such as the right to informed consent, presents the greatest challenges. Paradigms addressing the reality that medical care may have to be administered without informed consent have been, and need to continue to be, developed.

Creating an exception to the prohibition against euthanasia in disaster or extreme emergency situations, however, either by way of expressly incorporating its use into a framework for disaster response, or simply condoning it, has no legal or ethical foundation in our country and is not necessary as a means to cope with disasters. Involuntary euthanasia is directly contrary to the established principles of patient autonomy and self-determination and inevitably requires a determination by the physician of what is an acceptable quality of life for the patient. Carving out a disaster

19. AM. MEDICAL ASSN., CODE OF MEDICAL ETHICS 2.21 (1996), *available at* http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion221.shtml ("Euthansia").

exception to this prohibition would create a dangerous deviation from these principles under the most volatile circumstances and would jeopardize the most vulnerable individuals. Incorporating certain moral and legal absolutes in advance planning to guide decision-making in the chaos surrounding disasters or emergencies is clearly necessary. Ultimately, the tragedy involving the LifeCare patients and the allegations of euthanasia leveled against Dr. Pou, whether valid or not, and the ongoing moral and legal debate surrounding this situation and the reality that similar situations will occur, demonstrate the ongoing need for the development of disaster planning consistent with our society's legal and ethical principles.