CARING IN CRISIS
MANAGING ETHICAL AND LEGAL
CHALLENGES FOLLOWING
CATASTROPHIC DISASTER

THE AMERICAN ASSOCIATION OF NURSE ATTORNEYS
27TH ANNUAL MEETING AND EDUCATIONAL CONFERENCE
26 OCTOBER 2009 — TAMPA FLORIDA

CHAD PRIEST RN BSN JD
Baker & Daniels

OBJECTIVES

- Identify catastrophic disaster events, and appreciate the distinction between preparing for traditional disasters and catastrophic disasters.
- Case study of total system collapse: New Orleans & Hurricane Katrina:
  - The Hurricane
  - The Response (or lack thereof)
  - Conditions of Hospitals in New Orleans
  - What Happened at Memorial Medical Center?
- Managing legal and ethical challenges associated with providing acute care during and after a catastrophic disaster.

NURSING — A PROFESSION BORN OF CATASTROPHE

[Images of early nurses]
**Predictable Legal and Ethical Challenges During Disaster**

- Unclear policies and procedures/no practice
- Staff shortages (access problems, quarantine, injury and death)
- Licensure and scope of practice issues
- Manual charting/documentation problems
- Changes in the standard of care
- Fear and uncertainty
- Unfamiliarity with disaster triage or improper implementation

---

**Total System Collapse**

- All municipal, state, regional or federal safety-net systems fail (or appear to fail)
- No timely rescue possible: caregivers on shift operate in near-absolute isolation
- Basic services unavailable (electric, heat, water, air condition, sewage system, refrigeration)
- Presence of panic and breakdown of social order
- High potential for public health crisis

---

**Hurricane Katrina**
One of the strongest storms to hit the United States in 100 years.

- Sustained winds on landfall of 125 mph, roughly 100 mph in New Orleans.
- Strong winds and storm surge weakened levees causing failures at multiple points along the Mississippi River-Gulf Outlet Canal, the London Ave. Canal, 17th Street Canal, and Industrial Canal.
- Massive flooding impacted nearly 80% of New Orleans.
- 900,000 people without power
- 1,836 storm-related fatalities, nearly 1,577 in New Orleans. Another 500-800 persons missing.

Visit the National Climatic Data Center at http://www.ncdc.noaa.gov/oa/climate/research/2005/katrina.html
September 14, 2005: LifeCare Hospitals self-reported, through their attorneys, the possible euthanasia of patients following Hurricane Katrina by personnel working at Memorial Medical Center.

Louisiana Attorney General, through the Medicaid Fraud Control Unit, investigated.

Following the investigation, Attorney General issued arrest warrants for Dr. Anna Pou (ENT), Lori L. Budo and Cheri A. Landry on four counts of Principal to Second Degree Murder. (La. R.S. 14:30.1 – “the killing of a human being when the offender has a specific intent to kill or to inflict great bodily harm” – “[unlawful distribution or dispensation of] a controlled dangerous substance listed in Schedules I or II of the Uniform Controlled Dangerous Substances Law which is the direct cause of the death of the recipient who ingested or consumed the controlled dangerous substance”).

After being arrested, Pou, Budo and Landry were not formally charged for some time.
SUMMARY OF ALLEGATIONS

LifeCare operates LTAC inside Memorial. In the morning of September 1 it becomes clear that many LifeCare patients will die if not evacuated. There are no plans for evacuation.

- Pou informs the Assistant Administrator of LifeCare hospital that the LifeCare patients were not going to survive and that she was under the impression that these patients were not aware of what was happening. The administrator advised that one patient (“E.E.”) was alert and aware. It is not clear if Pou was told that the patient had been given sedatives. LifeCare refused. Pou tells administrator “I want ya’ll to know I take full responsibility and ya’ll did a great job taking care of the patients.”

- Pou informs the LifeCare DON that she intends to administer “lethal doses” to patients. The DON asks “lethal doses of what?” She also asks if it is limited to LifeCare patients and Pou allegedly responds “There is no telling how or why this will end.” Pou advises him that the DOH involvement LifeCare staff. LifeCare’s Director of Physical Medicine escorts Pou and two nurses to the seventh floor (LifeCare patients are on three floors at this point). At this point, the LifeCare staff is told to prepare for evacuation and to leave the floor. Pou tells staff that the LifeCare patients are “in our care now” and “you’ve done everything you can.”

- Pou requests syringes and supplies from the LifeCare pharmacist. The pharmacist and Dr. Pou discuss the condition of the patients. Pou informs the pharmacist that she intends to administer lethal doses of medication and displays multiple vials of Morphine. A subsequent search of the pharmacy and records reveals all of the requested doses from Pou were delivered.

- Dr. Pou has a discussion with one staff member who was uncomfortable with the proposed “sedation” of a patient that was well known to him. Pou allegedly says that if he isn’t comfortable with it, he shouldn’t do it. She goes on to say that “the first time she did it, it haunted her for two years.” The staffer decided against participating in the sedation.

- The Director of Physical Medicine and the LifeCare pharmacist observe Pou going in and out of patient rooms. They are observed drawing up medication in syringes and going into patient rooms to administer. Pou tells the staff that she is going to tell one patient (“E.E.”) that she is giving him something to help with his dizziness.

- Pou tells the LifeCare Director of Physical Medicine to do final sweep of floor to evacuate all LifeCare staff and to put sheets over the faces of dead patients. As the Director of Physical Medicine goes to the second floor to check on staff, it is prohibited from entering.

- The bodies of all patients who died at Memorial Medical Center were retrieved on September 11, 2005.

- Four patient bodies, including that of “E.E.” were autopsied. The test results were positive for morphine and midazolam. Test results and records indicate that the concentration of midazolam was less than expected from normal therapeutic dose. According to the forensic pathologist, none of the four patients were being administered morphine or midazolam for their routine care.

- Lori Budon, Cheri Landry and Anna Pou were identified by those present as the individuals giving the medications.

FORENSIC INVESTIGATION

- The bodies of all patients who died at Memorial Medical Center were retrieved on September 11, 2005.

- Four patient bodies, including that of “E.E.” were autopsied. The test results were positive for morphine and midazolam. Test results and records indicate that the concentration of midazolam was less than expected from normal therapeutic dose. According to the forensic pathologist, none of the four patients were being administered morphine or midazolam for their routine care.

- Lori Budon, Cheri Landry and Anna Pou were identified by those present as the individuals giving the medications.
Dr. Anna Pou is completely innocent of all allegations made by the state Attorney General. There is nothing in her character, background or morality that would support any of the outrageous charges made by the state of Louisiana.

RICHARD T. SIMMONS, JR.
Counsel for Dr. Pou
http://www.supportdrpou.com/

Many of us worked side by side with Cheri and Lori at Memorial Medical Center in New Orleans during the chaotic aftermath of Katrina under desperate, war zone-like conditions. In the deadly, sweltering heat, we desperately tried to provide medical care and comfort to gravely ill patients with inadequate food, running water, oxygen, or basic medical supplies.

Many of us were well aware that our salaries and pensions were at risk from the federal government for our dedication to save the lives of those we couldn’t save.

As professionals, we had to put aside the thought of our own well-being and the thought of our own lives. We knew that we had to make the decision to save the lives of those we could save.

We were not aware of the charges that were being filed against Cheri and Lori during our time at Memorial Medical Center.

As professionals, we had to put aside our own personal lives and the thought of our own well-being.

We were not aware of the charges that were being filed against Cheri and Lori during our time at Memorial Medical Center.

In light of these great personal sacrifices, we are outraged and heartbroken over the media circus surrounding their recent arrest. Tragically, the rescue helicopters and boats that finally arrived were too few in number and too late to save some of our patients – and THAT is the crime that happened in my hospital.

The primary and immediate cause of death for each of these patients was acute combined drug toxicity, specifically, morphine and versed.

...the manner of death would be classified as homicide.

Dr. Cyril Wecht - Forensic Pathologist

Baker & Daniels
“It is my opinion that these patients were terribly ill, with some very close to death. The external circumstances were horrific, i.e. no water, toilets, electricity, air conditioning – which I expect contributed, to some extent, to hastening their dying. However, after studying the charts carefully, I feel that the manner of death in these individuals, especially in four cases (names redacted), obligates the legal process to consider them as homicides.”

“It is my opinion, to a reasonable degree of medical certainty, that the administration of morphine and Versed shortened the lives of all nine patients; that the patients died as a result of the improper administration of morphine with and without Versed; that the immediate cause of eight of the deaths was acute morphine and Versed poisoning and one death was acute morphine poisoning; and that the manner of death for each is homicide.

“The facts of each of the cases stand on their own... I believe each individual case represents a cause of death of drug toxicity and a manner of death of homicide...”

“All these patient survived the adverse events of the previous days and for every patient on a floor to have died in one three and a half hour period with drug toxicity is beyond coincidence.”
Grand Jury returned a “no true bill” (no indictment) to the New Orleans District Attorney. As a result, Lori Budo, Cheryl Landri and Dr. Pou face no criminal charges related to their actions at Memorial Medical Center in the days following Hurricane Katrina.

Medical experts never testified in Katrina hospital deaths

Another doctor performed the initial triage and “all nine patients were Category 3 – the most critical and classified as ‘very sick’”

Another doctor evaluated the 9 patients and ordered PRN Morphine and an “anxiety medication”

Lifecare personnel who claim Dr. Pou said certain things were “mistaken or misunderstood”

Lifecare’s cooperation with AG is an effort to deflect attention from Lifecare’s failed evacuation plan.

The Lifecare pharmacy provided the Morphine and Versed [ANY GOOD LAWYERS IN THE ROOM??]

AG refused to release forensic information ahead of the grand jury.

Blood levels of Morphine are greatly increased in post-mortem specimens with the passage of time, rendering any quantitative measurement useless.”

None of the experts “seem to be familiar with how the dynamics of a collapsed hospital changes record keeping.”

The AG’s refusal to recognize the grand jury verdict and his effort to retry the case in the media through the selective release of documents and utilization of these experts is merely a form of character assassination without cross-examination. The AG should accept the decision of the citizens of New Orleans...”
“We begin with the general rule that doctors don’t kill patients…. even in extreme conditions, doctors have a responsibility to relieve pain and suffering, but not to the point of putting patients to death.” (Robert W. Donnell, MD quoting Dr. Mark Siegler, Director of the MacLean Bioethics Center at the University of Chicago at http://www.medscape.com/viewarticle/545058)

“The American Nurses Association (ANA) believes that the nurse should not participate in active euthanasia because such an act is in direct violation of the Code for Nurses, the ethical traditions and goals of the profession, and its covenant with society. Nurses have an obligations to provide timely, humane, comprehensive and compassionate end-of-life care.” (Ethics and Human Rights Position Statements: Active Euthanasia (12/8/94)).

tri·age (trē-āzh', trē'āzh'):

French, from trier, to sort, from Old French

(1) A process for sorting injured people into groups based on their need for or likely benefit from immediate medical treatment. Triage is used in hospital emergency rooms, on battlefields, and at disaster sites when limited medical resources must be allocated.

(2) A system used to allocate a scarce commodity, such as food, only to those capable of deriving the greatest benefit from it.

The ethical principle behind triage is to do the greatest good for the greatest number of casualties.

It has been said that triage merely creates the situation that enables providers to do the greatest good for the greatest number of casualties.

In a disaster you may be asked to make triage decisions based on both patient condition and resource availability.
In the general ethical framework for health services in the United States, each presenting patient will receive care and attention that will not be diverted to the next patient until (1) care for the first patient is underway or (2) that patient is transferred or referred.

“Decision-making during extreme conditions, however, shifts ethical standards to a utilitarian framework in which the clinical goal is the greatest good for the greatest number of individuals… Care decisions are not about ‘the most that can be done’ or ‘the best that can be done under perfect conditions’ but about what is sufficient given the specific conditions at the time.”

Triage process is dynamic and changes as the situation changes. Patients can get better, the situation can improve, patients can go downhill and the situation can always deteriorate.

Typical civilian triage (including “START”) presumes a certain level of resources.

Triage may need to change towards the military model in catastrophic disaster when resources are not available.

Few civilian medical providers understand how to implement catastrophic disaster triage techniques, in part because there have been so few true catastrophic disasters requiring implementation of this type of triage.

In a catastrophic disaster, there may be insufficient resources to provide the same quality of care you are used to providing.

Know your hospital policies with respect to disaster triage, and remember the principle driving triage decisions: “do the greatest amount of good for the greatest amount of people… with the available resources.”
Degradation of quality of care is expected in a catastrophic disaster.

Legal definition of “standard of care” is fluid, and is capable of shifting with changes on the ground in disaster situations.

Due to infrequency of catastrophic disaster, the law does not currently provide rigid rules/protections.

The law does set basement rules (e.g., Memorial Medical Center – New Orleans) that do not change based on conditions on the ground.

The intervention is the discussion. The discussion requires multiple intelligences/multi-disciplinary understanding.

Not many lawyers are equipped to lead the discussion.

You are.

“Much has been learned from the Katrina experience, and unless the government and the medical and legal communities take heed and effect change, we will miss one of the greatest opportunities for improving the management of national disasters. That would be one of the greatest tragedies of all.”

ANNA MARTA POU M.D.
CARING IN CRISIS
MANAGING ETHICAL AND LEGAL CHALLENGES FOLLOWING CATASTROPHIC DISASTER

Chad Priest, RN, BSN, JD
chad.priest@bakerd.com

Baker Daniels
300 N. Meridian St., Suite 2700
Indianapolis, IN 46204
(317) 237-1349
805 15th St. NW, Suite 700
Washington, DC 20005
(202) 312-7440

PHOTO CREDITS

ALAN CHIN
SLIGHT CLUTTER PHOTOGRAPHY