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Forced Abandonment and Euthanasia: A Question from Katrina

INTRODUCTION*

I DO NOT KNOW WHAT HAPPENED ON THE SEVENTH FLOOR OF MEMORIAL Medical Center (MMC) during the darkest hours of the New Orleans catastrophe.¹ We do know that, in addition to staff, patients and family members, hundreds of others had sought shelter in the hospital as hurricane Katrina approached Louisiana on Sunday, August 28, 2005. By Monday afternoon the storm had passed but the levee walls along the city's canals had begun to fail. A foul mixture of waters from the New Orleans sewer system and Lake Pontchartrain was coursing through the streets, eventually reaching the low-lying area where the hospital stood, inundating the lower floors of its buildings and submerging the cars in the hospital's parking lot. From the outside, MMC had become an island. On the inside, the electricity and plumbing were failing. The staff would have no lighting, no elevators, no toilets, no running water, no overhead pagers, no refrigeration, no air conditioning, no telephones, no ventilation, and no powered medical devices. The flood had crippled the hospital's capacity to provide standard medical care for its patients and, with perhaps 2,000 patients and refugees crowded together, Memorial Medical Center may have become a health hazard. Notwithstanding this, the staff continued to care for patients, moving those they could to the roof of a nearby parking garage, where they might be evacuated by helicopters, or to the second floor, where they might board water craft.²

As the days passed, many of those in the hospital were able to leave. But many hundreds remained, including the sickest patients who could not be moved, and the staff who were staying on to care for them until help arrived. There had been assurances of a timely rescue. But early Thursday morning—three days after the hurricane—it was announced that those still in the hospital would be on their own (Deichmann, 2006: 110). There would be no rescue by federal, state, or local government agencies. Dr. Richard Deichmann, the hospital's chief of medicine, described the effect:

It was a phenomenal blow to hear that nobody was coming to get us. The worst thing for us was always waiting for someone to come and get us and then never showing up. There was this feeling of betrayal all the time. That freezes your ability to do things. And that is what happened Wednesday and Thursday (Meitrodt, 2006).

Some clinicians may have concluded, perhaps reasonably, that both they and their patients had been abandoned.

After days of enervating heat, darkness, and sickening stench, some clinicians are said to have ended the lives of some patients before leaving the hospital themselves. No living patients were left behind. Alleging that there had been homicides, Louisiana's attorney general subsequently ordered the arrest of a doctor and two nurses.

It is unclear, at this writing, how many indictments there will be. It is too early to make a confident judgment about what the conditions were at MMC between its isolation in Katrina's floodwaters and the final evacuation by Tenet, the corporation that owned the hospital and that sent helicopters for the last survivors. Nor is it now possible to say who did what during the crisis and what they believed and intended at the time. Journalists have given us a preliminary account, the courts may follow with further evidence, and historians will eventually have the last word. But we may never know the full story.

Despite the obscurity of the actions and circumstances, Katrina has posed a new question that complicates our thinking about caring

for patients at the end of life. Can the conditions in a collapsing health care delivery system ever excuse euthanasia? The focus here is on the ethical norms that should govern health care professionals working *in extremis*. There is a need for responsible standards that, in fairness, should be honored by practitioners and respected both by the law and by society. What might those standards be?

In the pages that follow, I will, first, review some of the current thinking about the causation of death in the clinical setting, looking at some familiar standards from law and ethics. I will then consider the permissibility of euthanasia, focusing initially on what I will call the argument from “intractable suffering,” perhaps the strongest and most common justification. I will also survey objections to that argument.

With that as background, I will go on to look at disaster medicine and a different reason for withholding and withdrawing life support. When, following mass casualties, medical resources are in short supply, it becomes justifiable to withhold them from seriously injured patients, allowing them to die even though, on an ordinary day, clinicians would act aggressively to save them. In this context, I will consider an issue that has received comparatively little attention in mainstream bioethics: battlefield euthanasia. Circumstances that may be unheard of in civilian medical care are tragically more familiar in military medicine. I will show that conditions arising on the battlefield can mirror conditions that could have arisen during Katrina. Building on that discussion, I will develop and defend a professional standard for assessing the conduct of health care professionals who are, in this way, *in extremis*. If not a wholly new line of thought, the narrow defense of euthanasia that is offered here is at least one that has largely gone unnoticed in the bioethics literature. The argument from “forced abandonment” (as I shall call it) sidesteps some objections to the argument from intractable suffering.

So there will be no misunderstanding, the pages that follow are not intended as a defense of what health care professionals did in Louisiana. As has been emphasized, we do not know what that was. Current accounts of the events in question are neither comprehensive

nor consistent with each other and, indeed, it would not be a surprise to discover that some elements of my narrative are incorrect. But the argument of this paper does not turn on the accuracy of its account of the Katrina catastrophe. This inquiry is a more abstract one. Are there conditions that, had they been present in New Orleans (or anywhere else), would have excused ending the lives of patients, conditions under which both law and professional ethics should withhold condemnation? The answer offered here is yes. Where it is impossible to evacuate patients and dangerous and medically futile to remain with them, clinicians may have to choose between abandonment and euthanasia. There may be no third option. I will argue that physicians who choose euthanasia under these conditions should be excused from ethical and legal responsibility for misconduct. It would be wrong to blame them for what they have done.

The distinction between justifying and excusing conditions is central to what follows. When an act is justified, it is not a wrong at all: “I didn’t file a tax return because the law says I am not supposed to. Not filing a return was the right thing to do.” However when a wrongful act is excusable, the agent should not be blamed or punished for it: “I didn’t file a tax return because I was gravely ill at the time. While I should have filed, it would be wrong to fault me for having failed to do so.” Section II of this essay explores a common justification for one type of euthanasia. In contrast, Section III defends the excusability of another type.

EUTHANASIA AND THE MEDICAL CAUSATION OF DEATH

Euthanasia

The Greek roots of the term “euthanasia” denote “good death.” Though it is common to think of death as unequivocally bad—it is, after all, our most severe punishment—it is easy to distinguish between dying processes that are mercifully tolerable and others that are agonizing beyond endurance. During the events that have become known as 9/11, scores of people who were trapped in the World Trade Center leaped from windows to escape the heat and smoke, some holding

hands with others as they fell. Knowing their lives had come to an end, it is likely they were choosing deaths that were better than the ones they would suffer if they remained inside. Though it was tragic that so many died in this way, it does not appear to have been publicly argued that it was wrong for them to have ended their lives as they did.

Euthanasia requires a second person's involvement. Sometimes called "mercy killings," these acts are carried out by one person for the benefit of another. Again, the everyday inclination is to think that, except for self-defense and a few other cases where killing is justified or excused, it is a grave wrong to cause the foreseeable death of another human being, to harm another in that comprehensive way. But one can imagine oneself struggling through the heat and smoke to reach a window high in the World Trade Center. A coworker who uses a wheelchair is also there, but unable to get past the debris and into the air outside. She asks for your assistance.³

Euthanasia, as an ethical problem, has traditionally engendered debate on whether and, if so, when, killing another person can be justified or excused on the grounds that the person killed is benefited rather than harmed. Except in some European countries, euthanasia is a crime. Those who end the lives of the intractably suffering, even when they are following urgent requests, can expect to be charged with homicide. Should the law be changed to permit some beneficent killings?

Clearing the Ground

In examining euthanasia, three issues characteristically muddy the waters. First, "euthanasia" was the euphemism the Nazis used to sanitize their early extermination of those they deemed defective. The program quickly evolved to kill millions: Jews, Roma, homosexuals, communists, and so on. Treated as vermin, those who were involuntarily and secretly gassed in the concentration camps were not killed beneficently. Indeed "involuntary" euthanasia—"beneficently" killing another against his or her will—seems a contradiction in terms. While

some fear that loosening the law of homicide will send us down the slippery slope to holocaust, such prognostications must be examined with care.

The second issue concerns what some still call “passive euthanasia”: the discontinuation of life-prolonging measures, often the removal of a ventilator (a mechanical breathing device). When a patient or an authorized proxy withdraws consent to treatment, then the doctor, no longer at liberty to continue, can lawfully withdraw life support, causing death. It is sometimes urged that these patients die from their underlying diseases rather than from the doctor’s action. But if death is a foreseeable consequence, then the clinical removal of a ventilator kills a patient (Brock, 1993) just as surely as the removal of a regulator kills a deeply submerged scuba diver. The law of homicide already includes this special exception for doctors, and much of the ethical and legal discussion of death and dying turns on the patient’s legal and ethical power to refuse treatment, often through an advance directive and/or a legally authorized representative. While suffering can sometimes be averted by withdrawing life-support, this strategy is often unavailable and, moreover, the deaths caused by abating treatment may not be as tolerable as those that are induced. Nonetheless, it is nearly everywhere unlawful to administer medications for that purpose. Should this be changed?

Life-supporting treatment can also be withdrawn on the grounds that it no longer constitutes a benefit for the patient or, while it may be beneficial in some ways (prolonging life for a few additional days for example), the treatment is disproportionately harmful in other ways (painful or costly, for example). Doctors may be permitted to withdraw life support, causing death, on the grounds that continuing treatment would either be futile or harmful on balance: that is, not “medically indicated.” Here as well death is caused by the withdrawal of treatment.

The third issue has to do with physician-assisted dying, now legalized in Oregon. In this case a doctor provides the means to end life: commonly a prescription with special instructions. Note that the

doctor does not take the final life-ending step. While the reasons given for physician assistance are somewhat similar to the arguments for euthanasia (considered in Section II), I shall not explore them here.

I will now examine the active causation of death when it is done for the benefit of the one killed. Should the law of homicide be amended to permit some beneficent killings? I will consider two types of case where the defense of euthanasia is perhaps the strongest. The more familiar one arises in connection with intractable suffering. The argument from intractable suffering, together with some objections, will be explored in Section II. The second argument, in Section III, arises in connection with forced abandonment. It is, if perhaps not a novel argument, at least one that is less familiar. It is proposed that this second argument is sound and that, legally and ethically, such acts of euthanasia ought to be excused.

THE ARGUMENT FROM INTRACTABLE SUFFERING

The Standard Argument

Suffering commonly affects patients with a progressive illness—metastatic cancer, multiple sclerosis, Huntington’s disease, for example. As Hippocrates put it, they are or soon will be “overmastered” by disease. While much of the euthanasia literature focuses on pain, the suffering brought on by severe illness comes in many flavors: dizziness, diarrhea, disfigurement, itching, insomnia, incontinence, exhaustion, strains upon relationships, shortness of breath, anxiety, cognitive impairment and dementia, debt, depression, disabilities of all kinds, dependency, loss of control, nausea, offensive odors, and the loss of dignity that can accompany these. Such conditions are familiar to those who provide hospice care. Sometimes—but not always—symptoms can be managed while preserving positive elements that give value and richness to a waning life: talking with loved ones, listening to music, enjoying a sunset. But residual abilities too can succumb, even as a patient retains sensitivities that can make life intolerable.

One strategy is “terminal sedation.” Doctors can render a patient unconscious while withholding nutrition and hydration: death ensues

in a matter of days. But not every patient would prefer such “care” to a timely passing. There is a broadly understood difference between having a life and being alive in the biological sense. It is the former—the life one has—that is often paramount for a patient. As with those trapped on 9/11, that life can come to an end before death occurs.

When a human life deteriorates to the point where one reasonably desires to end it, the argument for the permissibility of euthanasia can turn on autonomy: the ethical and legal power, within civic constraints, to chart the course of one’s own life, especially in areas where the stakes that others have in the choice are not as great as one’s own. The root political idea is that, provided there are no sound and proportional countervailing reasons, adults should enjoy the freedom to make their own decisions.⁴ The presumption ought properly to be in favor of liberty: here the liberty of informed, suffering, competent individuals to choose the manner and time of their death. In the face of intractable suffering and an expressed and settled preference for death, there are strong arguments 1) that voluntary euthanasia should be permitted in these cases and 2) that it is cruel to prohibit or condemn charitable assistance to those who are relevantly similar to the 9/11 coworker in her wheelchair. Those who act out of courageous compassion in these cases are surely not the criminals we have in mind when we build prisons. Accordingly, public policy should regulate, but not prohibit, voluntary euthanasia.

The Objections

Objections to the argument from intractable suffering focus on the proviso that there be “no sound and proportional countervailing reasons.” Here it is useful to distinguish between “yellow light” objections, urging caution, and “red light” objections, admonishing one to stop. While the former express concerns about the possibility of adverse consequences, the latter hold that euthanasia is impermissible on its face.

Many are the yellow-light objections. There is the alleged slippery slope down which we can slide to holocaust. Further, compassionate

homicide might erode the professional commitments of physicians as well as our trust in doctors. (That might be a reason for barring the involvement of physicians.) There are the fears that patients will be depressed or pressured at the time of decision, that they may have been misdiagnosed, that haste in ending patients' lives can prevent possible recoveries, that relatives and health care providers will conspire to end the lives of the ill, and that protective measures will be unequal to the task of preventing carelessness and misconduct. These objections can be definitively assessed only when we have determined what protective measures we are talking about and how these have worked in practice. Here we can usefully study the Oregon record, as it becomes available, and the experience of the Dutch, the Belgians, and the Swiss. Unlike the Nazis, we can require our protocols to be implemented in the light of day. And even if some adverse consequences should occur following legalization, these would have to be measured carefully against the adverse consequences of prohibition.

Prematurity is a concern that permeates many of the yellow light objections: worries that life-ending decisions will be unnecessarily rushed. If only there were enough time to reconfirm the diagnosis, to labor with patients about their decisions, to try out other strategies for alleviating discomfort or for stopping the progress of the disease, to await new treatments that might suddenly become available, to rule out depression or undue pressures on the part of friends and relatives. . . . *If only there were enough time*, then many (most? all?) patients who now seem only *too* ready to let go of their lives might decide to hold on instead. Physicians have weighty duties to prevent the deaths of their patients or, failing that, to see them through the burdens of the dying process. When the death of another is a foreseen consequence, one wants to be sure there are no better options. Perhaps no one can ever be sure enough. There is here a venerable ideal of a certain type of therapeutic partnership between the vulnerable patient and the steadfast clinician. Even if a dying person is pleading for the relief that only death can promise, a clinician who kills a patient arguably betrays his or her commitment to that alliance.

Many of the red light objections emerge from within discrete religious traditions. These sectarian counterarguments often proceed from a premise that human life is, in some way, sacred, not to be discarded or taken; that euthanasia is, at bottom, a mortal sin. But in a pluralist society, the considerations that settle public issues ought to be ones that can, at least in principle, persuade any reasonable person: not just those who have embraced some preferred sectarian view.⁵ So if, for example, the closely related idea of human dignity can be given a secular interpretation—one that is both broadly persuasive and sufficiently weighty—and if the favored understanding of that idea mandates the continuation of medical care while precluding euthanasia, then it may be reasonable to keep the law of homicide as it is (Sulmasy, 1994). Such arguments would have to be examined in detail (Dworkin, 1994: 68-101, 179-217).

No position is taken here on whether the argument from intractable suffering is sound or whether any of the listed objections constitute effective refutations. I now proceed to the second argument.

THE ARGUMENT FROM FORCED ABANDONMENT

Disaster Triage

In a disaster, there may not be enough to go around. The number of patients who present at a hospital can significantly exceed its carrying capacity and, moreover, it may not be possible to transfer them to other regional medical centers. Plane crashes, explosions, epidemics, and the release of toxic gas: all of these (and others) can overwhelm the resources of a community's hospitals.

Hospitals everywhere practice specialized procedures for these events. Disaster triage is the distinctive sorting method used in patient intake. Clinicians must narrow their attentions to patients who will probably live if treated but probably die if untreated. Using colored tags and rapid assessment techniques, they will set aside patients without life-threatening injuries (the "walking wounded") and those who will likely die despite treatment. Patients in this last group—sometimes termed "expectant" and identified with black tags—are not abandoned.

They receive ongoing comfort care (pain medications) and medical reassessments, especially if they unexpectedly survive the period of scarcity. On an ordinary day, the patients who are set aside to die would usually be treated aggressively, and many might survive. What would be a serious wound in a hospital with an untapped surge capacity can become a fatal injury in a hospital coping with disaster.

These queuing procedures are intended to save the maximum number of lives. Because there is not enough to go around, it is imperative to avoid waste. Resources are wasted when they are expended on patients who are likely to die even if they receive treatment (the black-tagged, most severely injured) or likely to live even if treatment is withheld (the walking wounded, the least severely injured). But resources will be efficiently used if clinicians prioritize those who will live if treated but die if untreated, the group in the middle. And, within that subset, those who are both closest to death and most easily treated will receive medical attention first.

Notice that the reason for withholding life-prolonging treatment from black-tagged patients has nothing to do with intractable suffering nor with any decision these patients have made about having had enough. There is a dramatic shift in these situations from an individualized doctor-patient relationship to something more like a public health perspective, with attention refocused on the group rather than on the individuals making it up. Compassion and individualized commitment, so much the pride of everyday clinical practice, can cost lives during a disaster. A skilled emergency physician will complete a physical assessment in no more than 90 seconds. The colored tag is attached and it is on to the next patient. The goal is to have saved, at the end of the day, the maximum number of lives.

Catastrophe and Battlefield Euthanasia

In a *medical disaster*, the resources of a health care setting are overwhelmed. Triage helps to solve the problem. In contrast, a *medical catastrophe* occurs when a health care delivery system collapses (Kipnis, 2003: 95-107). The hospital (or any setting where medical care

has been provided) has somehow become hazardous to the point where all must relocate to safety. Though this may or may not have occurred at Memorial Medical Center, there are scenarios where this condition would be met. Here are three.

1. An earthquake and ongoing aftershocks have caused structural damage and are threatening to topple occupied sections of a now burning hospital.
2. Biological, chemical, or radiological agents have contaminated the buildings even while the clinical staff are unprepared to protect themselves.
3. A deadly epidemic is fueling riots by angry mobs who believe that essential supplies are being hoarded inside.

In all three cases, clinicians and patients are present in the hospital and, for different reasons, it is not safe for them to remain.

The argument from forced abandonment arises against the background of a medical catastrophe: the collapse of a health care delivery system. It becomes applicable when, in addition, it is impossible to evacuate black-tagged patients and impossible to remain with them. While rare, such conditions are more familiar in battlefield medicine. In his World War II personal narrative, *The Road Past Mandalay*, John Masters recounts one such episode (Masters, 1979: 277-78). Commanding a British unit in Burma, he and 2,000 of his men are being forced to retreat by a fresher and better-equipped Japanese force. A doctor has summoned him.

The stretchers lay in the path itself, and in each stretcher lay a soldier of 111 Brigade. The first man was quite naked and a shell had removed the entire contents of his stomach. Between his chest and pelvis there was a bloody hollow, behind it his spine. Another had no legs and no hips, his trunk ending just below the waist. A third had no left arm, shoulder or breast, all torn away in one piece. . . .

Nineteen men lay there. A few conscious. At least, their eyes moved, but without light in them.

The doctor said, "I've got another thirty on ahead, who can be saved, if we can carry them. . . . These men have no chance. . . . None can last another two hours, at the outside."

I said aloud, "Very well. I don't want them to see any Japanese." . . . Shells and bombs burst on the slope above and bullets clattered and whined overhead.

"Do you think I want to do it?" the doctor cried in helpless anger. . . . "We can't spare any more morphia."

"Give it to those whose eyes are open," I said. "Get the stretcher bearers on at once. Five minutes."

He nodded and I went back up to the ridge, for the last time. One by one, carbine shots exploded curtly behind me. I put my hands to my ears but nothing could shut out the sound.

There are several features that are worth noticing in this description.

1. There is, in the background, a medical disaster. The 19 men who can no longer be saved have, in effect, been black-tagged but not abandoned. They are receiving narcotics and, with difficulty, are being evacuated. The medical objective is to save as many lives as possible and to insure that even the most severely injured receive care and attention that is appropriate under the circumstances.
2. The moving British unit is attempting to carry out an organized retreat from an attacking Japanese force. Their lives depend on the execution of this difficult maneuver. Whatever semblance of a clinic that existed before the retreat began, nothing is left of it now. A medical catastrophe has occurred.
3. It appears to be impossible to evacuate the black-tagged patients without risking the lives of 30 less severely wounded soldiers. One

supposes that further casualties would be expected if the retreat were interrupted.

4. It is not possible for the doctor to remain behind with the black-tagged patients. Were he to do this, it would be a culpable abandonment of the other wounded soldiers in the unit. He would likely be captured or killed by the advancing Japanese and he has weighty duties not to let either of these happen.
5. It appears to be unacceptable to abandon the black-tagged patients to capture by the Japanese. Perhaps it is believed that they will be mistreated; or that they will not be provided with appropriate medical attention during their remaining hours; or that, grievously wounded and left alone to die, they will endure deaths that human beings should be spared, if possible, by those caring for them. The officer may also appreciate what he would be required to do with Japanese wounded were the situation reversed.
6. Though neither the doctor nor the officer says so, it is evident that the issue is whether to euthanize the gravely injured soldiers before moving on. It is striking that the two men *are not deliberating*. Their common purpose seems rather *to confirm the inevitability of a profoundly unwelcome choice*.

The Question from Katrina

I can now address the question with which we began: Can the conditions in a collapsing health care delivery system ever excuse euthanasia? As on the battlefield, health care professionals and their patients, during massive civilian disasters like Katrina, can also be compelled to evacuate. Should it prove impossible to relocate the black-tagged patients, health care professionals will have only three choices: they can remain with their patients, they can leave them behind, or they can euthanize them before leaving themselves (Swann, 1987).

The first option, remaining with the black-tagged patients, tests the commitments of physicians, nurses, and others. While the obligations that clinicians have to their patients are weighty, it would be hard to defend the proposition that they are absolute: to be honored

regardless of the costs to the caregivers and to others with competing claims. To be sure, the continuing presence of health care professionals may extend somewhat the lives of dying patients, may make the dying process more endurable, and may express a community's commitment to respect the dignity of those in the greatest need. But whatever the sources and the weight of the duty to remain with patients, it is an open question what burdens health care providers must shoulder to fulfill this professional obligation, and what expectations others (clinician's families, other patients) must forfeit. A catastrophic collapse of a health care system can require doctors and nurses to work without proper equipment in uncontrolled environments; without adequate food, water, or sleep; and amid hazards that threaten their own lives and health. What they can accomplish by remaining may be precious little and far less than what they might do elsewhere. At some point they may have done everything required of them.

There appear to be two distinct justifications for setting a limit to the obligation to remain with patients where leaving them would constitute abandonment. In the first place are *unreasonable personal burdens* that health care professionals and their families would have to take on were they to remain. Family members and others may also suffer significant derivative loss. In the second place are *competing professional obligations*. As with the doctor in the Burma narrative, other patients may have weightier claims than the black-tagged patients. In a disaster, allocation rightly shifts resources to where they can do the most good. Accordingly, any decision to remain with victims who are beyond saving may violate weightier obligations to attend to salvageable patients in urgent need of vital care. For these reasons, I will assume in what follows that the prohibition on abandoning patients cannot be absolute.

One other consideration is worth mentioning. Consider the risks routinely taken by firefighters, soldiers, and police officers. Notice that the community helps them do their jobs in reasonable safety. Firefighters receive breathing equipment and protective clothing. The burden of remaining at one's station despite hazards does not fall solely on their

shoulders. Society must support essential services if it is to expect men and women to act heroically when the need arises. Now whatever the social obligation of firefighters to enter burning buildings, it is arguably diminished when a community fails to provide protective equipment and other forms of support. Likewise, if a community expects health care professionals to remain steadfast during a catastrophe, it must be prepared to support them through the darkest hours so they can keep at their work while protecting themselves. But when health care professionals are abandoned by the communities they serve, the duty to brave hazards may be attenuated.

If, as I have argued, there is a line delimiting where there is no duty to remain, and if it is reasonable to judge that it has been crossed, health care professionals could conclude that they were at liberty to leave. But having chosen to leave, clinicians would then face a second dilemma: either abandon the black-tagged patients to die unmedicated and unattended, or euthanize them before leaving themselves. There is no third option.

Two of the weightiest medical norms are here in collision: the prohibition against abandoning patients and the prohibition against killing them. Where it is impossible to evacuate patients and dangerous and medically futile to remain with them, one of these two norms *must* give way.

In the professions of medicine and nursing, there is a broad consensus on the twin issues of nonabandonment and euthanasia. While euthanasia has been heavily contested in the professional literatures, that is less so of nonabandonment. Loyalty and fidelity to patients and clients are commonly invoked as core professional values. Patients and clinicians stand in a fiduciary relationship. At the center is trust on the part of the patient and *a reciprocal commitment to be worthy of that trust* on the part of the clinician. Accordingly, it is a serious matter for a doctor to “fire” a patient: for nonpayment of bills or for imposing unnecessary risks on staff and other patients. Physicians are well advised to give notice in writing, and with ample time for the patient to obtain the services of another caregiver. Likewise, nurses know that

they may not leave their units if there are not enough staff to care for the patients. While leaving a gravely ill patient alone, to die unattended and unmedicated, would be a paradigmatic violation of professional ethics—an egregious betrayal of loyalty—the pertinent principles were not conceived in the light of medical catastrophe.

Along with abandonment, euthanasia is also commonly prohibited by authoritative professional standards.

Facing the Dilemma

To fix ideas, let us restrict our focus to cases that arise only under the following three conditions.

1. The care setting has become hazardous to the point where clinicians are no longer under a duty to remain.
2. The patients who are being attended in the care setting are not expected to survive with the treatments that are available there. Nor is it expected that supplemental clinical resources will become available in time to improve their prognoses.
3. It is not possible to evacuate these patients.

There are at least three considerations that support excusing euthanasia under these specific circumstances.

1. Clinicians who abandon the care setting early, leaving others to take up the common burden, are able to sidestep the problem. Only the clinicians who stay on to the last will have to choose which of the two medical norms they will betray. To charge these men and women with criminal or professional misconduct would be to discourage or punish the very heroism they earlier displayed by remaining at their posts despite the hazards and to encourage early desertion as a way of avoiding censure. Taken together, these pragmatic considerations amount to a powerful justification for withholding condemnation.

2. Earlier, in Section II, I reviewed certain “yellow light” objections based on prematurity. I noted that steadfast clinicians might

refrain from ending the lives of intractably suffering patients out of a worry that such an irrevocable step would be premature—other strategies might still be tried. But forced abandonment puts a full stop to such reflection. Once the patient is unattended, no further care can be on offer. When the only other option is to abandon the patient (no care at all), it may be that *the best treatment* would be one that beneficently and painlessly ends life. The euthanizing of black-tagged patients under conditions 1 through 3 above may represent “appropriate care under the circumstances”: the least-worst option. On this argument, forced abandonment would *justify* euthanasia rather than merely excuse it. Not only would it be a reasonable choice: it would be the right choice.

3. But even if it could not be shown that euthanasia is the preferred option, faced with the forced choice, it remains that neither option is plainly the wrong one. The ethics literature does not authoritatively prioritize the prohibitions on abandonment and euthanasia when circumstances dictate that one of the two must give way. The two norms seem always to be considered independently, perhaps because it is not imagined that they can conflict. Clinicians who are forced to choose between the two are therefore not in violation of professional ethics, considered as a whole. If it cannot be maintained that a clinician made the wrong choice under the circumstances, there is no basis for condemnation. Notwithstanding the violation of a weighty norm, the offense, if there is one, should be excused. The circumstances forced a choice between two weighty norms, one of which had to be violated. In the absence of an accepted priority rule, neither choice should be condemned, and either choice should be excused.

Were one to apply this standard to the events at MMC, here are the questions that would have to be addressed. First, did the conditions that followed Katrina require the evacuation of the hospital? A positive answer to this question might establish that the clinical staff was no longer required to remain in the hospital.

Second, were the remaining patients likely to die despite the best effort that might be made with the staffing and resources then available in the hospital? Was it reasonable to believe that supplemental

clinical resources would not arrive in time to improve their prognoses? A positive answer to these questions would establish that the patients were not expected to survive.

Third, was it reasonable to believe that rescue efforts to evacuate the remaining patients would not arrive in time to improve their prognoses? A positive answer to this question would establish that the remaining patients were not expected to be evacuated.

Where all three conditions are satisfied, clinicians must choose between abandoning their patients or euthanizing them before leaving themselves. Paradoxically, *it is precisely because each of the two options stands as an egregious violation of an important health care norm, and because there is no third option, that neither violation can be rightly condemned.* We can only have compassion for those who had to face the forced choice.⁶

If my analysis of the issue is correct and if, in the end, it turns out to be applicable to the events at Memorial Medical Center, then, narrowly, as a matter of professional ethics and law, what clinicians did or did not do during the darkest hours of the New Orleans catastrophe might not be consequential. To be sure, patients suffered and certainly some died. And we can imagine a small number of clinicians, tired, overworked, despondent about the lack of support, having to make one of the most painful and vexing moral decisions human life can force upon anyone. We can imagine clinicians reasonably concluding that their hospital has become hazardous, that their patients cannot be evacuated nor are they expected to survive, and that no one is coming to help. We can imagine clinicians telling any patients who were still alert enough to understand:

Because of the disaster, we can neither keep you alive for very long nor can we move you to a safer location. This hospital has become dangerous and help is not on the way. The staff must evacuate. We can leave you as you are, hoping for the best but realistically expecting something quite bad. Or we can provide you with drugs that will put

you into a deep sleep from which you will never awaken. You can make the choice to die soon, with us still here with you rather than after we have gone. We have no other option to offer. Please help us to make this decision.

While the argument from forced abandonment may have a broadly understood application on the battlefield, its requisite conditions are exceedingly rare in civilian settings. If the conditions were satisfied at MMC, that event might be one of only a handful where a civilian health care institution collapsed catastrophically. It should not be a worry that the decision to excuse euthanasia in these extremely rare circumstances will lead inexorably to the Nazi gas chambers.

The problem of euthanasia arises *in extremis*. In one case, the life of a suffering person approaches a ruinous and horrific end. In a second, rarer and less studied case, a collapsing health care system is unable to minister to the most grievously afflicted. It can be distressing to ponder what it might be like when such important matters go so dreadfully awry, and difficult to discern professional responsibilities when they do. But these tragedies do befall us, challenging our capacities to craft decent and just social practices, and to act rightly out of charity, compassion and respect.

NOTES

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- 1. The seventh floor of MMC had been leased by LifeCare Hospital. A separate hospital within a hospital, LifeCare patients were among the most gravely ill in the building (Deichmann, 2006: 64-65).

2. My sketch of these well-reported events is drawn from hundreds of sources, the most important of which were reports in the *New Orleans Times-Picayune* and the *New York Times*. Jeffrey Meitrodt's five-part series in the *Times-Picayune* ("For Dear Life: How Hope Turned to Despair at Memorial Medical Center") offers an excellent overview (Meitrodt, 2006). MMC's chief of medicine has written a first-person narrative of his experience during the episode (Deichmann, 2006).
3. If it is permissible, under the circumstances, to do some one thing oneself (leaping to one's death from a World Trade Center window), one must ask why it would not, by implication, be equally permissible to lend assistance to another who reliably and reasonably desires to do that same thing, but is physically unable to do so? While I believe this issue is worth pursuing, I will pass over it here.
4. Among the many proponents of this highly influential idea are John Stuart Mill (1985), John Rawls (1999), and Joel Feinberg (1987).
5. The issues here are well explored in John Rawls' *Political Liberalism* (Rawls, 1993: 35-40, 133-72).
6. It would be still be appropriate to condemn others who, in various ways, allowed or caused conditions to deteriorate to a point where only those two unwelcome options remained.

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