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The Law of Death and Dying
Dean Boozang
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The Story of Hurricane Katrina and Memorial Hospital

In the early morning hours of August 29, 2005 the Gulf Coast braced for disaster.¹ A category 3 hurricane named Katrina was descending upon Louisiana. Hurricane Katrina produced damaging winds up to 140 mph; 10-16 inches of rain water and storm surges up to 14 feet.² New Orleans, Louisiana, a city surrounded by water and below sea level, felt the greatest effects of the storm.³ The city, which was already in peril, was seriously damaged when fifty-three levees breached, sending floodwaters indiscriminately throughout the city.⁴ By the time the storm was over, 1,100 people had died in Louisiana, a majority from New Orleans.⁵

After the storm, national attention turned to woefully late recovery efforts initiated by the Federal Government.⁶ New Orleans was designated a disaster zone; completely abandoned, being overrun by looters freely walking the streets causing fear and chaos to those clinging for survival.⁷ Hospitals were overwhelmed with the surge of patients and were ill equipped to battle the power outages and lack of evacuation assistance.⁸ With that said, no hospital has come under more scrutiny than Memorial Medical Center (“Memorial”). At Memorial, decisions were made to shut down the hospital, triage patients based on incorrect standards and provide end of life

¹ Select Bipartisan Committee, U.S., Cong., H.R., A FAILURE OF INITIATIVE: FINAL REPORT OF THE SELECT BIPARTISAN COMMITTEE TO INVESTIGATE THE PREPARATION FOR AND RESPONSE TO HURRICANE KATRINA 7 (2006).

² *Id.*

³ *Id.*

⁴ *Id.* at 73.

⁵ *Id.* at 74.

⁶ Sheri Fink, *The Deadly Choices at Memorial*, N.Y. TIMES, Aug 25, 2009, available at <http://www.nytimes.com/2009/08/30/magazine/30doctors.html> (last visited Dec. 4, 2013).

⁷ *Id.*

⁸ *Id.*

palliative care to not so critically ill patients.⁹ The hospital and its medical care providers faced life or death decisions while treating severely ill and injured patients in worsening conditions.¹⁰

Following the storm, questions were raised as to why there were so many deaths at Memorial. After an investigation, it was speculated that the reason for the high number of casualties resulted from the decision to euthanize patients who could not be evacuated.¹¹ The investigation centered upon Dr. Anna Pou (“Dr. Pou”) and Nurses Cheri Landy and Lori Budo who faced criminal charges for questionable decision making involving the deaths of four patients.¹²

How It Unfolded: Katrina Makes Landfall

The city of New Orleans’ response to Katrina began on August 28, 2005 when Louisiana’s then-Governor Kathleen Blanco, with the advice of President George W. Bush, insisted that New Orleans Mayor Ray Nagin evacuate the city.¹³ The mandatory evacuation order, which did not include hospitals, caused the roads out of New Orleans to become congested with bumper to bumper traffic resulting in thirty mile delays.¹⁴ Worsening the situation was the lack of ambulatory and air lift options for city hospitals.¹⁵ Also of note is that Louisiana hospitals

⁹ *Id.*

¹⁰ *Id.*

¹¹ *Id.*

¹² Gina Castellano, *The Criminalization of Treating End of Life Patients with Risky Pain Medication and the Role of the Extreme Emergency Situation*, 76 FORDHAM L. REV. 203, 204 (2007). (discussing the allegations at Memorial Hospital).

¹³ See BIPARTISAN, *supra* note 1, at 63.

¹⁴ Bradford H. Gray & Kathy Hebert, *After Katrina; Hospitals in Hurricane Katrina; Challenges Facing Custodial Institutions in a Disaster*, 18 J. Health Care for the Poor and Underserved 283, 285-294 (2007) (discussing lessons learned by hospitals from Katrina).

¹⁵ *Id.* See LOUISIANA HOSPITAL ASSOCIATION, <http://www.lhaonline.org/> (last visited Dec. 3, 2013). (The Louisiana Hospital Association was established in 1926, the Louisiana Hospital Association (LHA) is a not-for-profit association representing all types of hospitals and healthcare systems throughout the state. The LHA carries out its mission by providing services and resources to members through advocacy, education, research, representation and communication. The Hospital Association provides member hospitals with a range of

and nursing homes are not required by the Louisiana Hospital Association to maintain a specific emergency response or evacuation plan.¹⁶ The majority of hospitals followed the established protocol of “sheltering in place”, based on an ideology that patients would be safer in the hospital rather than risking complications during evacuation.¹⁷ Memorial, a private, for profit hospital owned by Tenet Healthcare Corporation (“Tenet”) followed the lead of other area hospitals and “sheltered in place” rather than evacuate before the impending storm.¹⁸ When the storm made landfall on Monday morning, approximately 300 hundred patients and 1,500 citizens looking for shelter from the storm were left stranded at Memorial.¹⁹ Reports claimed that some 600 workers remained at the hospital, among them Dr. Pou, who is at the center of the Memorial controversy. Dr. Pou was a cancer surgeon on the faculty of Louisiana State University School of Medicine, and was responsible for supervising residents at Memorial. To Dr. Pou’s credit she decided to remain at Memorial and help those in need.²⁰

On Tuesday, August 30, 2005 Governor Blanco ordered a mandatory evacuation of New Orleans.²¹ By 11:00 am, several sections of the levee system in New Orleans began to breach, submerging 80% of the city.²² The storm punished Memorial, resulting in windows being shattered, city power failed and Memorial’s interior was transformed into a “fetid Third World despair” as described by Dr. Pou.²³ The hospital was without electricity, running water or air

services including legal representation, financial services as well as being advocates for hospitals through their efforts in bill passages aimed at protecting the medical community). *Id.*

¹⁶ See BIPARTISAN, *supra* note 1, at 268.

¹⁷ *Id.*

¹⁸ Susan Okie, *Dr. Pou and the Hurricane – Implications for Patient Care during Disasters*, 358 NEW ENG. J. MED. 1, 1-5 (2008) (discussing Dr. Pou and her actions at Memorial during Katrina).

¹⁹ See Gray & Hebert, *supra* note 14, at 290.

²⁰ See Fink, *supra* note 6.

²¹ See BIPARTISAN, *supra* note 1, at 73.

²² *Id.*

²³ See Fink, *supra* note 6.

conditioning.²⁴ The temperature rose to over 110 degrees and the smell of dead bodies became “so rancid it would burn the back of your throat.”²⁵ As if things could not get worse, a sewer grate began to overflow, sending contaminated water towards the hospital.²⁶ Understanding that it would not take much water to disable Memorial’s main generated emergency-power, the remaining staff understood that they desperately needed to evacuate the remaining 180 patients left from the initial evacuation attempt.²⁷

Susan Mulderick, a nursing director served as the rotating “emergency-incident commander” for Katrina and was tasked with communicating with hospital executives and make decisions during the disaster situation.²⁸ Although she had helped draft the emergency preparedness plan for Memorial, the 246 page document was of no assistance regarding a futile situation of complete power loss and impassible roads due to flooding.²⁹ Without the chief of medicine, Dr. Richard Deichmann (“Dr. Diechmann”), the medical department chairmen of Memorial, along with Mulderick gathered a group of physicians to begin making triage decisions regarding evacuation and treatment of the remaining patients.³⁰ The group decided that they would first evacuate infants in the neonatal intensive-care unit, pregnant mothers, and critically ill adult I.C.U patients.³¹ Dr. Deichman then initiated a strategy that was nowhere in the hospital’s disaster plan; he decided, with the consent of the other physicians, that Do Not Resuscitate (“DNR”) patients would be last because as Deichamn put it, they had the “least to lose.”³² During the next two days, hospital workers would make the arduous trek of manually moving

²⁴ *Id.*

²⁵ *Id.*

²⁶ *Id.*

²⁷ *Id.*

²⁸ *Id.*

²⁹ *Id.*

³⁰ *Id.*

³¹ *Id.*

³² *Id.*

patients to the roof for evacuation.³³ With little sleep, food or water, workers transferred patients through a three foot wide opening, which led to a parking garage where a truck was waiting to drive patients to the top of the garage.³⁴ From there, workers had to manually carry the patients the remaining two flights of stairs where emergency helicopters waited to evacuate Memorial's chosen patients.³⁵ By Tuesday evening, the hospital was able to evacuate fifty-seven patients bringing the total of patients left to be evacuated at one hundred and twenty-three.³⁶ Fifty-two of the remaining patients were patients of LifeCare, a hospital that leased the seventh floor of Memorial to operate a long-term acute care unit. Most LifeCare patients were bedbound and not included in the triage decisions because Memorial was under the impression that LifeCare would be implementing its own evacuation plan.³⁷

By Wednesday, the auxiliary generators had shut down, the hospital temperature rose to 110 degrees and deceased bodies filled Memorial.³⁸ With little food or water, patients continued to fight for their lives, and Memorial could be described as a third world war zone.³⁹ Outside the hospital, civil unrest began to take hold of New Orleans streets.⁴⁰ This resulted in a decision by State Police to evacuate everyone from the hospital by 5 pm on Thursday.⁴¹ Police officers informed Memorial's hospital staff that they would no longer stay to protect the hospital and it became apparent that there would no longer be any rescue attempts after this mandated curfew was implemented.⁴² When it seemed like all was lost, there was finally some good news when

³³ *Id.*

³⁴ *Id.*

³⁵ *Id.*

³⁶ *Id.*

³⁷ *Id.*

³⁸ *Id.*

³⁹ *Id.*

⁴⁰ *Id.*

⁴¹ *Id.*

⁴² *Id.*

Tenet sent six helicopters, along with boats, to evacuate the remaining patients from Memorial.⁴³ With the curfew bearing down upon the hospital, controversial decisions were made when it was decided that some patients were too sick to be evacuated.⁴⁴ Critically ill patients, triaged as “3’s”, were the only remaining patients left while evacuations were taking place.⁴⁵ From reports and interviews with hospital workers, it was understood that Dr. Pou along with nurses Cheri Landry and Lori Budo began providing palliative end of life care to patients deemed too critical for evacuation.⁴⁶ By Thursday’s end, the hospital was completely evacuated, the hospital workers were credited for their tremendous work in saving many lives but questions remained regarding the final hours at Memorial.⁴⁷

The horrible events at Memorial shined a light on a complicated situation where both federal and state regulations create gray areas for medical providers in emergency situations. This paper will examine the decision made by Dr. Pou and her nurses to provide palliative end of life care and Dr. Diechman’s decision to triage DNR patients to the end of the evacuation line. By examining the existing protocols and legal standards in the medical profession, it will become apparent that medical professionals nationwide need the type of immunity created by the Louisiana legislature after Katrina. This type of immunity is necessary in order to provide the best care for the most people in a disaster emergency situation. Using Katrina and Memorial as a guide, this paper will show the necessity of immunizing health care providers for *good faith* efforts in treatment decisions, but will shed light regarding questionable decisions made by health care professionals providing palliative end of life care and triage decisions at Memorial.

Overview of the Two Issues

⁴³ See Gray & Hebert, *supra* note 14, at 293.

⁴⁴ See Okie, *supra* note 18, at 3.

⁴⁵ *Id.*

⁴⁶ See Castellano, *supra* note 12, at 204.

⁴⁷ See Gray & Hebert, *supra* note 14, at 292.

What constitutes a *bad faith* decision regarding medical treatment in a disaster emergency situation? Should the judgment of that question be a judicial one, or be based on a decision rendered by medical experts? Lastly, how can one prove intent to kill, which constitutes homicide, rather than intent to ease suffering which is legal during a doctor and patient relationship?

The two questions regarding *bad faith* decisions made at Memorial are: first, was it a *bad faith* decision made by Dr. Pou to provide palliative end of life care to patients, and second was it a *bad faith* decision for Dr. Diechmann to make triage decisions based on DNR orders. Answering these two questions will help shed light on the debate as to whether medical providers should be granted immunity for *good faith* decisions made in a disaster emergency situation.

Hospitals have a duty to plan for scenarios like the one at Memorial where resources are depleted and patients are in need of care.⁴⁸ The Joint Commission has required disaster planning by hospitals for over thirty years.⁴⁹ Hospitals must comply with comprehensive standards for emergency situation management to become accredited with the Joint Commission.⁵⁰ The standard requires organizations to identify potential emergencies that could affect them, and to develop a plan that addresses the four phases of emergency management activities. These four phases are; mitigation, preparedness, response and recovery.⁵¹ The Joint Commission makes it clear that mitigation and preparedness are extremely important in order for hospitals to come out of these emergency disaster situations.⁵² Although federal mandates and the Joint Commission

⁴⁸ *Improving America's Hospitals; The Joint Commission's Annual Report on Quality and Safety*, The Joint Commission, <http://www.jointcommission.org/> (last visited Dec. 4, 2013).

⁴⁹ *Id.*

⁵⁰ *Id.*

⁵¹ *Id.*

⁵² *Id.*

require certain protocols be implemented, it is up to the local hospitals to create their own Emergency Operation Plan.⁵³ Although mandated by the Joint Commission to have an Emergency Operations Plan, the Louisiana Hospital Association did not provide any guidance in developing emergency response or evacuation plans prior to Katrina.⁵⁴ According to hospital employees at Memorial, the emergency response plan instituted at the hospital provided no guidance for a disaster of such magnitude and the decision made by most hospitals was to “shelter in place.”⁵⁵ Without a specific guide during Katrina, it was up to hospital employees to make their own decisions regarding evacuation and treatment.⁵⁶ As to what constitutes a *bad faith* decision in a disaster emergency situation like Katrina is still open for debate.

Problem 1: Was Palliative End of Life Care Improperly Administered?

Whether Memorial’s medical providers should be immunized from liability depends upon whether they euthanized their patients or rendered palliative end of life care. Palliative care is specialized medical treatment provided to a serious ill patient with a goal of easing pain and improving the patient’s quality of life.⁵⁷ It is defined by the World Health Organization as care that “improves the quality of life for patients and families who face life threatening illness, by providing pain and symptom relief, spiritual and psychological support from diagnosis to the end of life and bereavement.”⁵⁸ During non-emergent situations, protocol for palliative sedation is administered based on factors involving assessments with family members and doctors.⁵⁹ During Katrina, medical providers were restrained by the storm and unable to follow the proper

⁵³ *Id.*

⁵⁴ Richard Moore, *Prepare to Defend more Medical and Nursing Facilities; Planning for Catastrophic Emergencies*, 50 No. 6, DRI, The Voice of the Defense Bar 1, 1-4 (2008) (discussing liability during catastrophic emergencies).

⁵⁵ *Id.*

⁵⁶ *Id.*

⁵⁷ See Castellano, *supra* note 12, at 208.

⁵⁸ George P. Smith II, *Refractory Pain, Existential Suffering, and Palliative Care: Releasing an Unbearable Lightness of Being*, 20 CORNELL J.L. & PUB. POL’Y 469, 473-474 (2010-11) (discussing end of life care).

⁵⁹ *Id.* at 497.

protocols to provide palliative end of life care. Medical providers were forced to make decisions regarding palliative care based on their own ethical determinations since Memorial's emergency response plan once again offered no guidance.⁶⁰

Opposite of palliative end of life care is euthanasia. Euthanasia is the administration of a lethal agent to a patient by another person to relieve the patients "intolerable and incurable suffering."⁶¹ Euthanasia is illegal in the United States as it involves the intent to kill, but some states have begun allowing physician assisted suicide.⁶² The legal problem arises from the differentiation of voluntary euthanasia and providing palliative end of life care with terminal sedation through pain medication.⁶³ Legally, health-care providers are allowed to treat pain with medication even when that medication possesses a risk of hastening a patient's death.⁶⁴ The main issue surrounding terminal sedation and palliative end of life care with pain medication revolves around whether or not the "intent of the physician should be the standard for criminalization."⁶⁵ If the intent of the physician is to euthanize a patient, then that physician is liable for murder.⁶⁶ Whereas if a physician provides palliative care to a seriously ill patient, intending to ease the patients suffering and hasten the death of a foregone patient with pain medication, then that physician should be absolved from all liability.⁶⁷

Historically, medical treatments provided to patients without their express consent were considered battery. Battery at common law is defined as an intentional unpermitted act causing harmful or offensive contact with the "person" of another.⁶⁸ Legal standards of care may be

⁶⁰ See Okie, *supra* note 18, at 3-4.

⁶¹ *Id.*

⁶² *Id.*

⁶³ *Id.*

⁶⁴ *Id.*

⁶⁵ *Id.*

⁶⁶ *Id.*

⁶⁷ *Id.*

⁶⁸ The Free Dictionary, <http://legal-dictionary.thefreedictionary.com/battery> (last visited Dec. 4, 2013).

defined as the minimum amount of care and skill a health care practitioner should exercise in particular circumstances.⁶⁹ In other cases, courts have found medical practitioners liable for their actions even though, based on the circumstances; their acts were consistent with the prevailing medical standards of care.⁷⁰ In most cases courts have taken the view that a doctor extending treatment beyond that expressly contemplated by the patient may be held liable for a battery unless he acts with the patients express or implied consent.⁷¹ Express consent is consent that is directly authorized by the patient, whereas the more complex situation involves implied consent in emergency situations.⁷² The general rule involving implied consent is that in emergency disaster situation in which immediate action is necessary for the protection of life, and it is impracticable to obtain actual consent; implied consent is asserted during those unanticipated emergency conditions threatening the patient's life.⁷³ In these emergency situations it is the physician's duty to do what the occasion demands within the "usual and customary" practice standards among physicians and surgeons in the locality.⁷⁴

⁶⁹ Hood v. Phillips, 554 S.W.2d 160, 165 (Tex. 1977).

⁷⁰ Helling v. Carey, 519 P.2d 981 (1974). Physician was found negligent for not performing certain tests on his patient. The court found that even though the test wasn't part of the "standards of profession" that it was relatively inexpensive and safe. The court held, that the "precaution of giving this test to detect the incidence of glaucoma to patients under 40 years of age is so imperative that irrespective of its disregard by the standards of the ophthalmology profession, it is duty of the courts to say what is required to protect patients under 40 from the damaging results of glaucoma. *Id.* at pinpoint

Cantebury v. Spence, 464 F.2d 722 (D.C. Cir 1972). Plaintiff consented to back surgery and the defendant (surgeon) did not tell him about the dangers and risk of the surgery. The surgery resulted in paralysis. Plaintiff claims he was not given all the details and would not have consented if he knew all the facts. The holding imposes duty on physician to inform patients of all risks associated with surgery as well as places a standard that physicians can only perform medical procedures that were consented to by the patients with the only exceptions being in emergency situations. *Id.* at pinpoint

⁷¹ W.E. Shipley, *Liability of physician or surgeon for extending operation or treatment beyond that expressly authorized*, A.L.R.2d 695, 696 (1957).

⁷² *Id.*

⁷³ Restatement (First) of Torts § 62 (1934)., (provides that an invasion of an interest of personality of another who has not consented thereto does not give rise to liability if ... (2) an emergency has arisen which makes it actually or apparently necessary to invade the interest before there is an opportunity to obtain consent.).

⁷⁴ *Id.*

After the waters receded and New Orleans began to understand the destruction, criminal liability was rumored to be descending upon Dr. Pou, and nurses Landry and Budo.⁷⁵ The arrest affidavit released by Louisiana’s Attorney General Charles C. Foti alleged that Dr. Pou committed second-degree murder “on or about September 1, 2005, by intentionally killing multiple patients by administering or causing to be administered, lethal doses of morphine and/or midazolam at Memorial Medical Center.”⁷⁶ The affidavit ended with the findings of the forensic pathologist who “advised that in all four cases it appeared that a lethal amount of morphine was administered.”⁷⁷ The affidavit further alleged that none of the four patients were being administered morphine or midazolam for their routine pharmaceutical care requirements.⁷⁸ Adding to the troubling findings in the affidavit is the claim that the four patients receiving pain medication were conscious and aware of the situation around them.⁷⁹ According to sources, consent was not given to Dr. Pou or the nurses working with her, but rather it seems that Dr. Pou and the medical professionals at Memorial decided that palliative end of life care was their decision to make when further evacuation of these patients seemed improbable.⁸⁰

Dr. Pou has vehemently defended herself stating that “she did not murder those patients nor does she believe in euthanasia.”⁸¹ She furthered stated that she doesn’t believe it’s anyone’s right to decide when a patient dies, but that she believes in comfort care, and that means ensuring that patients do not suffer pain.⁸² With that said, four deaths were explicably tied to a high level of morphine and midazolam, and the question remains, did Dr. Pou and her two nurses effectively

⁷⁵ See Castellano, *supra* note 12, at 204.

⁷⁶ *Id.*

⁷⁷ *Id.*

⁷⁸ *Id.*

⁷⁹ See Fink, *supra* note 6.

⁸⁰ *Id.*

⁸¹ See Okie, *supra* note 18, at 1.

⁸² *Id.*

ethanize these patients or should they be immune from liability because they acted ethically in providing palliative end of life care with pain medication.⁸³

A theory that the law might look to for guidance in dire emergency situations like Katrina and Memorial is the doctrine of double effect.⁸⁴ The doctrine clearly hypothesizes that “taking the life of another is always morally impermissible, yet when this results from actions carrying foreseeable but unintended harm, it may be permissible when the action is itself a moral act producing proportionate good.⁸⁵ The principle is laid out as four elements: first that the agent only intends to bring about good, that foreseeable harms are unintended and not a means to that good, that the intended means is morally permissible and that the intended good is proportionate to the unintended harm.⁸⁶ Double effect theorizes that an actor with good intentions is not responsible for the unintended bad effects.⁸⁷ In Dr. Pou’s case, using the theory, “as long as she intended to ease the pain of her patients and not cause death, even though death resulted, she is not culpable.”⁸⁸ Dr. Pou has adamantly denied euthanizing the patients in question and has stated that she believes in comfort care, by providing her patients with legally permissible pain medication to ease suffering.⁸⁹ But the question remains, how does one prove Dr. Pou’s intent? The answer can really only be determined by Dr. Pou herself. While others in the hospital can theorize what she may have been thinking, a medical professional’s decision to provide a patient

⁸³ See Castellano, *supra* note 12, at 204.

⁸⁴ See Smith II, *supra* note 56, at 500-01.

See *Washington v. Glucksberg*, 521 U.S. 702, 117 S.Ct. 2258 (1997), and *Vacco v. Quill*, 521 U.S. 793, 117 S.Ct. 2293 (1997). Supreme Court justices with the majority holding that the principal of double effect is recognized within American jurisprudence and should be employed when determining culpability of a physician in regard to his or her patient’s death if caused by terminal sedation or pain treatment. *Id.*

⁸⁵ *Id.*

⁸⁶ See Castellano, *supra* note 12, at 220-24.

⁸⁷ *Id.* at 206.

⁸⁸ *Id.*

⁸⁹ See Okie, *supra* note 18, at 1.

with palliative end of life care cannot be second guessed because the downside of this result would be patient suffering and medical professionals waiting for their inevitable death.

Medical professionals are not allowed to effectively euthanize patients while claiming the deaths were merely unintended effects of end of life care.⁹⁰ Health care providers are legally allowed to treat pain with pain medication even if that medication poses a risk of hastening a patient's death.⁹¹ In administering pain medication, physicians must follow criteria that states: any risky pain relief is necessary, the pain is intractable, that less dangerous but effective analgesics do not exist, and that the dosage be titrated upward in a careful fashion.⁹² While treating these patients, it is unquestionably acceptable to provide medication that may hasten death when the intent of the health care provider is to relieve pain.⁹³ The dilemma remains in a disaster emergency situation where medical providers may act because a patient is suffering extreme pain and to relieve this pain the medical provider is unable to follow the proper protocol.⁹⁴

The majority of the medical community has stated that aggressive pain treatment is necessary and expected to be provided by medical professionals.⁹⁵ Supreme Court Justice John Paul Stevens' concurring opinion in Washington v. Glucksberg, stated that a physician's refusal to dispense medication to ease the suffering of their patient and make their death dignified and tolerable would be inconsistent with the physicians healing role.⁹⁶ Furthermore, medical commentators have said that it would be medical malpractice for physicians caring for severely ill patients not to know how to use pain medicine, and not to use it aggressively when a patient is

⁹⁰ See Castellano, *supra* note 12, at 208.

⁹¹ See Washington v. Glucksberg, 521 U.S. 702 (1997).; Vacco v. Quill, 521 U.S. 793 (1997).

⁹² See Castellano, *supra* note 12, at 212.

⁹³ *Id.*

⁹⁴ *Id.*

⁹⁵ *Id.* at 214-16.

⁹⁶ Washington v. Glucksberg, 521 U.S. 702, 748 (1997) (Stevens, J., concurring).

dying in pain.⁹⁷ To clarify the point, the President's Commission Report for the Study of Ethical Problems in Medical and Biomedical and Behavioral Research, issued during the Ronald Reagan presidency, defers to the medical judgment of doctors, holding that physicians are not held to have violated the law when using potent pain treatment because society places an "importance on defining physicians' responsibilities regarding these choices and on developing an accepted and well-regulated social role that allows the choice to be made with due care."⁹⁸ The report further stated that if the patient is terminal and there is no further treatment that can extend the patient's life, then it's difficult to see how the physician deprives the patient of meaningful life by the treatment, rather it is the disease that deprives the patient of life.⁹⁹

The medical provider's intent in disaster emergency scenarios is nearly impossible to determine, but for the betterment of society it is imperative that these medical professionals be free to provide the care they believe is in their patient's best interest. The medical profession clearly believes that it is necessary for medical professionals to provide palliative end of life to patients who are seriously ill and suffering end of life pain. The unanswered question is whether or not Dr. Pou and her colleagues were in fact practicing palliative end of life care and was it properly administered.

Problem 2: Were DNR Patients Incorrectly Triageed?

The aftermath of Katrina raised a second issue: whether or not medical providers at Memorial acted in *good faith* by triaging patients with DNR orders to the end of the evacuation line. DNR orders are medical instructions written by a patient that instructs health care providers not to do cardiopulmonary resuscitation ("CPR") if breathing stops or if the heart stops

⁹⁷ See Castellano, *supra* note 12, at 214-16.

⁹⁸ President's Comm'n for the Study of Ethical Problems in Med. and Biomedical and Behavioral Research, *Deciding to Forego Life-Sustaining Treatments: Ethical, Medical and Legal Issues in Treatment Decisions* 79 (1983).

⁹⁹ *Id.*

functioning.¹⁰⁰ The order allows a patient the opportunity to choose to decline resuscitative treatment before an emergency occurs.¹⁰¹ Signing a DNR order does not affect other treatments but rather focuses solely on CPR if breathing stops or the heart stops beating.¹⁰²

Triage historically evolved in the military context, and the idea of saving the most in need was replaced by the “greatest good for the greatest number rule.”¹⁰³ Current triage models are based on “sorting patients for treatment in situations of at least modest resource scarcity, according to an assessment of the patient’s medical condition and the application of an established sorting system or plan.”¹⁰⁴ The United States uses a system scaling patients between one and five, with one being the most acutely ill patients and five being the expectant death patients.¹⁰⁵ In disaster mass casualty situations like Katrina, the World Medical Association has recommended that clinicians categorize disaster victims with a system that has been adopted worldwide involving the following triage criteria:

- 1) Priority 1: Those who can be saved but whose lives are in immediate danger requiring treatment within a few;
- 2) Priority 2: Those whose lives are not in immediate danger but who need urgent but not immediate medical care;
- 3) Priority 3: Those requiring only minor treatment;
- 4) No Specific Tag: who are psychologically traumatized and might need reassurance or sedation if acutely disturbed; and
- 5) Expectant (Death): Those whose condition exceeds the available therapeutic resources, who have severe injuries such as irradiation or burns to such an extent and degree that cannot be saved in the specific circumstances of time and place, or complex surgical cases that oblige the physician to make a choice between them and other patients.¹⁰⁶

¹⁰⁰ *Do Not Resuscitate Orders*, US National Library of Medicine, <http://www.nlm.nih.gov/medlineplus/ency/patientinstructions/000473.htm> (last visited Dec. 4, 2013).

¹⁰¹ *Id.*

¹⁰² *Id.*

¹⁰³ Kenneth V. Iverson & John C. Moskop, Triage in Medicine, Part I: Concept, History, and Types, 49 *Annals of Emergency Medicine* 275, 275-79 (2007) (discussing the history of triage).

¹⁰⁴ *Id.* at 278-79.

¹⁰⁵ *Id.*

¹⁰⁶ *Id.*

The World Medical Association states that it is “unethical for a physician to persist, at all costs at maintaining the life of a patient beyond hope, thereby wasting to no avail scarce resources needed elsewhere.”¹⁰⁷ The importance of triage decisions cannot be overlooked. In a disaster emergency situation it is necessary to have a plan in place to make these decisions which will result in the saving of the greater number of lives.¹⁰⁸ Intrinsic to the decision to triage patients are ethical considerations as to who should live and who should die.¹⁰⁹ In order to effectively triage patients the ethical parameters upon which decisions will be based as to who lives and who dies should be decided pre-emergency and be housed in existing protocol rather than decisions made during an emergency.¹¹⁰ Additionally different physicians may have different views about triage systems creating ethical and legal implications for hospital personnel in the time when aid is most needed.¹¹¹ It is recommended that a triage plan be evaluated by both legal and ethical experts before being put into place.¹¹²

As Katrina mercilessly battered Memorial, it became apparent that evacuation would become problematic for even the healthiest of patients. While waiting on federal, state and local aid, aid that may never arrive, it became the duty of the medical providers to make the hard choices in order to save the most lives.¹¹³ The first treatment decisions made at Memorial were to triage patients and decide who should be evacuated first.¹¹⁴ Hospital administrators began contacting other local hospitals, informing them that they needed to evacuate over 180

¹⁰⁷ *Id.*

¹⁰⁸ Kenneth V. Iverson & John C. Moskop, *Triage in Medicine, Part II: Underlying Values and Principles*, 49 ANNALS EMERG.MED. 282, 282-86 (2007) (discussing the principles of triage).

¹⁰⁹ *Id.*

¹¹⁰ *Id.*

¹¹¹ *Id.*

¹¹² *Id.*

¹¹³ See Fink, *supra* note 6.

¹¹⁴ *Id.*

patients.¹¹⁵ Although federally mandated by FEMA, there was no organized plan for this evacuation.¹¹⁶ Memorial did have an emergency plan but the plan did not offer guidance for dealing with a complete power failure or how to evacuate the hospital if the city became flooded.¹¹⁷

Dr. Deichman along with the others assembled in the command center decided that evacuation priority would be; babies in the neonatal intensive care unit, pregnant mothers and critically ill adult I.C.U patients, who were at the greatest risk from the intense heat.¹¹⁸ The physicians also agreed that patients with DNR orders should go last because they would have “the least to lose” compared with other patients if tragedy struck.¹¹⁹ Triage patients based on DNR orders was nowhere to be found in Memorial’s 246 page emergency preparedness documents, and this classification forced many patients to the end of the evacuation line.

By Wednesday, August 31, 2005, President George W. Bush declared a Public Health Emergency for the Gulf Coast and organized a task force to control the relief effort.¹²⁰ By 2:00 am of that day, Memorial’s auxiliary generators had shut off sending life support monitors into battery mode. Physicians and nurses frantically began to move more patients to a helipad for evacuation. Physically exhausted from working without sleep and with no relief in sight they forged on without water, electricity and a first floor flooded with a “soupy ocean of sewage water.”¹²¹ After surviving the night, the physicians gathered in the command center to discuss the remaining patients at Memorial.¹²² They decided to implement a “reverse triage” plan for the

¹¹⁵ *Id.*

¹¹⁶ *Id.*

¹¹⁷ *Id.*

¹¹⁸ *Id.*

¹¹⁹ *Id.*

¹²⁰ *Id.*

¹²¹ *Id.*

¹²² *Id.*

remaining patients at Memorial and those on the seventh floor maintained by LifeCare.¹²³ A reverse triage scheme treats the less wounded in preferences of the more severely wounded.¹²⁴

The physicians categorized the remaining 123 Memorial patients and 52 LifeCare patients as “1” those that were in fairly good health, could sit and walk. Patients characterized as “1’s” were prioritized for evacuation first.¹²⁵ The next group, characterized as “2’s” sicker than “3’s,” were taken to a waiting area to be evacuated following the “1’s”.¹²⁶ Finally, the “3’s” were moved to a corner in the hospital to wait for eventual, if ever, evacuation.¹²⁷ Among the “3’s” were those whom physicians deemed to be very ill and those with DNR orders. The problem that emerged was that the characterization of “3’s” forced some patients that were ill but not dying stay behind while others without DNR orders were given priority evacuation status.¹²⁸ Dr. Diechner’s initial decision and the reverse triage decision excluded patients with DNR orders from evacuation. In an interview with The New York Times, Mark LeBlanc told the story of how his mother was triaged as a “3” and would not be evacuated.¹²⁹ His mother who had the DNR order for all of her admissions into the hospital, had made the decision that she did not want to be revived if her heart failed.¹³⁰ She did not make the decision to not be evacuated because she had a DNR but because she was improperly triaged as such.¹³¹ LeBlanc wouldn’t take no for an answer when being told that his mother would not be evacuated and instead evacuated her himself.¹³² Another precarious incident occurred with Angela McManus who in an interview told

¹²³ *Id.*

¹²⁴ *Id.*

¹²⁵ *Id.*

¹²⁶ *Id.*

¹²⁷ *Id.*

¹²⁸ *Id.*

¹²⁹ *Id.*

¹³⁰ *Id.*

¹³¹ *Id.*

¹³² *Id.*

a story of how her mother was not initially evacuated because of a DNR order.¹³³ The order which her mother had in place before entering the hospital was signed by her doctor, a doctor who was not at the hospital to rescind the order leaving Angela's mother as a "3" triage level and unable to be evacuated.¹³⁴ These two situations along with other patients triaged as "3's" highlight the question, was it in *bad faith* to triage patients based on DNR orders?

Louisiana's Response

Following the grand jury's decisions to not indict Dr. Pou, Dr. Pou felt that it was necessary to protect her and other medical professionals if a situation like Katrina occurred again. Realizing that there are no comprehensive national liability protections for health care practitioners but rather different liability protections at both the federal and state level, Dr. Pou lobbied the Louisiana legislature to change this. Through her advocacy, three laws were passed in Louisiana to help aid future healthcare professionals during a declared natural disaster.¹³⁵

The first statutory reform that the Louisiana legislature passed was Senate Bill 330 which amended the existing Good Samaritan statute.¹³⁶ The statute protects a health care professional during a declared natural disaster regardless of whether or not they were compensated.¹³⁷ The statute protects medical personnel from "simple negligence" and only allows for liability for "gross negligence" or "willful misconduct."¹³⁸ Senate Bill 330 aims to protect volunteers and those that stay and work even though they are not compensated. In the situation of Dr. Pou and the other employees of the hospital, she advocated, and the legislature agreed that they should not face liability when they stayed to help during Katrina. Although the hospital was technically

¹³³ *Id.*

¹³⁴ *Id.*

¹³⁵ *Id.*

¹³⁶ La. Rev. Stat. Ann. § 37:1731.1 (2008).

¹³⁷ *Id.*

¹³⁸ *Id.*

closed, they continued to work and attend to their patients. The legislature in implementing this bill understood how important it was for these medical providers to stay and provide aid and wanted to ensure that in future situations the same outcome would occur.

The second statutory reform passed by the Louisiana legislature was Senate Bill 301 which gives “immunity for simple or gross negligence by doctors and nurses, thereby protecting them from civil damage as a result of the evacuation or treatment decisions (as well as failed evacuation or treatment) at the direction of the military or the government in accordance with “disaster medicine” protocols.”¹³⁹ The statute recognizes that “medical personnel should not bear civil liability for such disastrous situations unless involved in intentional misconduct.”¹⁴⁰ This statute is important to Dr. Pou and her colleagues. It is necessary that these physicians be able to make *good faith* decisions regarding the medical treatment of their patients during emergencies. These decisions include triaging patients based on the proper protocols approved by the hospital, evacuation decisions stated in the hospitals procedures manual during emergency and general treatment decisions by physicians during emergency situations.

The third and final bill that Dr. Pou advocated for and the Louisiana legislature passed was House Bill 1379. This bill sets up a unique “Disaster Medicine Review Panel” concept to examine medical judgment during declared disasters.¹⁴¹ The act establishes a panel of three members consisting of the coroner, a member of the medical community and a disaster medicine expert appointed by the Governor.¹⁴² These three will make an independent decision based on a standard of care as to whether the medical decisions were “*good faith* medical judgment given

¹³⁹ La. Rev. Stat. Ann. § 29:735.3 (2008).

¹⁴⁰ *Id.*

¹⁴¹ La. Rev. Stat. Ann. § 40:1299.39.3 (2008).

¹⁴² *Id.*

the disaster circumstances under which the judgment was rendered.”¹⁴³ With regards to criminal liability, and important to Dr. Pou’s advocacy in light of her situation, is that the Prosecutor will refrain from arresting the medical personnel until the three person panel has rendered a determination.¹⁴⁴ The bill also works as a safeguard for physicians who understand that the person judging their medical decision is one of their peers in the medical community.

What’s Next? The Necessity of Immunity for Health Care Providers In a Future Katrina Like Situation

The charges against Dr. Pou would not result in an indictment but the controversial deaths of patients at Memorial still begged the question of whether or not the decisions made that day were in *good faith*. Defining what constitutes *good faith* should be determined in a tribunal setting similar to the one set up in Louisiana House Bill 1379. A panel of medical experts should examine the complex scenarios and determine if medical professionals acted in *bad faith* during emergency disaster situations or whether medical professionals provided the proper care as justified by the local medical community. Similarly to a situation like Memorial, it would be up to the panel to determine whether Dr. Pou was acting in *bad faith* to euthanize the patients in question or rather was acting in *good faith* while providing end of life palliative care.

Furthermore, it would be the panel’s responsibility to determine if the triage decisions made by Dr. Diechmann resulted in *bad faith*. Judging by the existence of historical triage protocols, it would be difficult to determine that triaging patients with DNR orders was a correct approach. Whether or not the doctors actions constituted bad faith should be determined by the panel created under Louisiana House Bill 1379. Understanding how difficult this determination would

¹⁴³ *Id.*

¹⁴⁴ *Id.*

be and the complexity of the process, it seems imperative that nationwide legislation be put into place for future Katrina like scenarios.

The theory of “double effect” should act as the guide for determining what decisions are made in *good faith* and those that are made in “*bad faith*.” Inherently, the belief is necessary that medical professionals act in *good faith* while treating their patients. It is this inherent belief that allows for such things as confidentiality and on the reverse side allows for medical professionals to perform necessary medical procedures without fear of recourse. It is imperative for relief in an emergency disaster situation that there is an implied belief that medical professionals act in *good faith* while delivering aid to patients.

Attorney General Foti’s investigation focused on twenty-five deaths, not caused by natural causes.¹⁴⁵ The investigation narrowed in on the four deaths of Emmett Everett, Rosie Savoie, Ireatha Watson, and Hollis Alford.¹⁴⁶ The results of the autopsy showed that none of the four victims were terminally ill and the forensic pathologist concluded that all four had lethal doses of morphine and that all four were expected to live through the storm.¹⁴⁷ Concerning to the issue of *good faith* decision is the complication that the group being investigated all had DNR orders.¹⁴⁸ Further disconcerting, are the reports of many of the victims being conscious at the time of the terminal sedation.¹⁴⁹ In the interviews conducted for the indictment, others in the hospital testified that all four patients were resting comfortably and none of them had complained of pain on the day they were injected.¹⁵⁰ None of the patients were under the care of Dr. Pou or the

¹⁴⁵ Charles I. Lugosi, *Natural Disasters, unnatural deaths: the killings on the life care floors at Tenet’s Memorial Medical Center after Hurricane Katrina*, 23.1 *Issues in Law & Medicine* 71, 71-6 (2007) (discussing the controversial deaths at Memorial).

¹⁴⁶ *Id.*

¹⁴⁷ *Id.*

¹⁴⁸ See Fink, *supra* note 6.

¹⁴⁹ *Id.*

¹⁵⁰ *Id.*

nurses accused of helping to inject them, and according to testimony, none of them were aware of the medicine they were being given.¹⁵¹

Dr. Pou maintains her innocence and maintains that she was providing legally permissible end of life palliative care. The majority of the medical community came to her support following her arrest. Following her statements, that she was only providing “comfort care” in a horrible situation, the Louisiana State Medical Society issued a press release stating that they were confident that Dr. Pou performed courageously under the most challenging and horrific conditions and that she made decisions in the best interest of the patients.¹⁵² They further commented that her long and distinguished career as a talented surgeon and dedicated educator should not be tarnished as a result of the accusations.¹⁵³ Articles were written in the local medical community summarizing her long and dedicated career with commentary from the medical community describing her as compassionate and being held in the highest regard.¹⁵⁴

The above mentioned bills are necessary to protect medical providers who risk their lives and careers to provide aid to those in need during an emergency disaster situation. Without federal legislation similar to the legislation passed in Louisiana, medical providers will be less willing to stay and provide aid during an emergency disaster situation. Analyzing commentary and surveys provided by the medical community, it is apparent that they believe it is necessary to protect medical providers from criminal charges in these situations. Many in the medical profession point out that the criminalization of Dr. Pou’s treatment decisions will have an adversely dangerous effect on future emergency disaster response.¹⁵⁵ Commentators point out that “nobody

¹⁵¹ *Id.*

¹⁵² Louisiana State Medical Society, <http://www.lsms.org/Newsroom/LSMS%20Stmnt%20on%20Anna%20Pou.pdf> (last visited Dec. 4, 2013).

¹⁵³ *Id.*

¹⁵⁴ *See* Okie, *supra* note 18, at 1-3.

¹⁵⁵ *See* Harrell & Lambert, *supra* note 165, at 74.

is going to want to stay in these extreme emergency situations, resulting in pain going untreated.”¹⁵⁶

Timothy Quill, director of palliative care at the University of Rochester Medical Center came to the defense of Dr. Pou, stating that the drugs she used were typical for palliation, not euthanasia.¹⁵⁷ He pointed out that there were no paralytics or barbiturates used, that these drugs would point to a person trying to end the life of a patient.¹⁵⁸ He furthered commented that the drug levels given to the patients were comparable to those given in palliative care and that Dr. Pou was just trying to do the right thing in an awful situation and was doing the best that she could.¹⁵⁹ Although there are reports that Dr. Pou injected patients that were not terminally ill, the medical community believes that she was acting in *good faith* to care for these patients in dire situation. Dr. Pou was acting in *good faith* when she administered comfort palliative care to patients that Memorial believed would not survive an evacuation attempt. That belief cannot be questioned; medical providers will be less willing to help. The amount of victims that were saved during this horrific scenario by medical providers, who could have easily left, goes unnoticed.

Finally, in 2006 the Community Health Planning and Policy Development Section of the APHA conducted an electronic survey of prospective volunteer health practitioners.¹⁶⁰ The study asked potential volunteers about the importance of immunity from civil lawsuits in deciding whether to volunteer during emergencies.¹⁶¹ Almost 70% of participants responded that it was important or essential.¹⁶² The study asked several other questions regarding liability and whether

¹⁵⁶ *Id.*

¹⁵⁷ *See* Okie, *supra* note 18, at 3.

¹⁵⁸ *Id.*

¹⁵⁹ *Id.*

¹⁶⁰ LAWRENCE O. GOSTIN ET AL., Institute of Medicine of the National Academies, *CRISIS STANDARDS OF CARE, A SYSTEMS FRAMEWORK FOR CATASTROPHIC DISASTER RESPONSE*, 1-61 The National Academies Press, 1st ed. (2012).

¹⁶¹ *Id.*

¹⁶² *Id.*

or not medical personnel would volunteer in an emergency situation.¹⁶³ Not surprisingly, the survey made it clear that many participants would be reluctant to take on extended roles without some assurance that they would be protected from prosecution or litigation.¹⁶⁴ Furthering the point, Cheryl Peterson, a senior policy fellow for the American Nurses Association was quoted as saying “if you want practitioners to continue to respond to disasters, you cannot put them in a position when they are making very difficult decisions where they’ll be second guessed by someone who is not there.”¹⁶⁵ The survey responses along with commentary from the medical community point to the importance of creating a comprehensive federal bill protecting health care provider’s immunity from both criminal and civil liability for *good faith* decisions regarding treatment in disaster emergency situations.

Conclusion

For the foregoing reasons, physicians should be granted immunity for *good faith* decisions made in emergency disaster situation. The laws passed in Louisiana are at the forefront of what legislation should be in the United States. There should be federal protection for medical providers during emergency disaster situations in order to prevent resources from withdrawing their help for fear of liability. With a strong umbrella of liability protection, aid will be more readily provided to people that need it the most.

As for the situation at Memorial, the physicians, nurses and other hospital employees were unaware that they would ever be put in a situation like Katrina. Their hospital disaster response plan left them woefully unprepared. Their decision to triage patients based on their DNR orders was incorrect, but their goal of saving as many patients as possible, while working

¹⁶³ *Id.*

¹⁶⁴ *Id.*

¹⁶⁵ Adrine Harrell & John Lambert, *Management dilemma for healthcare providers in the wake of Hurricane Katrina*, 4.1 Academy of Health Care Management Journal, 69, 74 (2008) (discussing medical providers unwillingness to help in situations of liability).

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day and night in deplorable conditions is commendable. Medical providers should not face criminal or civil liability for their actions in situations like Katrina. The benefits far outweigh the negatives in imposing liability on medical professionals at a time when they come to the aid of those most in need during a disaster emergency situation.