



ETHICS IN PUBLIC HEALTH EMERGENCIES: AN ARIZONA CODE OF PUBLIC HEALTH EMERGENCY ETHICS

As of February 15, 2012

Sponsored by: The Lincoln Center for Applied Ethics
and the Public Health Law & Policy Program,
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INTRODUCTION

Overview: Ethical issues are pervasive in public health emergency responses, including decisions related to the allocation and use of scarce resources, the appropriate application of limitations on personal liberty to protect the public, and the provision of public health and health care services to individuals and populations. Lack of consensus for public health ethical norms applicable in emergencies has led to widely divergent approaches nationally and regionally. In Arizona, public and private actors have not engaged in consensus-building efforts to date to develop widely-accepted principles to guide ethical decision-making in emergencies in Arizona.

Goals: The primary objective of this project is to develop generally-applied principles of public health emergency ethics via consensus among public and private actors in Arizona. The goal is to produce a “model code” of public health emergency ethics to help guide critical decisions among public and private sectors during public health emergencies.

Disclaimer and Limitations: Please note that the information provided in this document is based on available input and guidance from national experts in public health ethics and emergencies, a focus group convened at ASU's SkySong facility on November 4, 2011,ⁱ and a working groupⁱⁱ to develop the model code, as well as independent research and development. These principles and the model code do not represent the official policy of the Arizona Department of Health Services, other state or local agencies or private sector entities.

ⁱ The focus group included James G. Hodge Jr., Erin C. Fuse Brown, Daniel G. Orenstein, Lexi C. White, Peter French, Russ Mosser, Tia Powell, Matthew Wynia, Lance Gable, Aubrey Joy Corcoran, Timothy Lant, Doug Campos-Outcalt, Gary Quinn, Megan Jehn, Daniel Rothenberg, Kimberly Goodwin, Tina Wesolowskie, Shad Bustamante, Carol Lockhart, Aaron Klassen, and Kathleen O'Connor.

ⁱⁱ The working group included members of the focus group plus Antonio Hernandez, Martin Matustik, and Joseph Herkert.

ARIZONA MODEL CODE OF PUBLIC HEALTH EMERGENCY ETHICS

Format: The Arizona Code of Public Health Emergency Ethics includes core principles of public health emergency ethics (numbers 1, 2, 3 . . .) together with proposed code language (1.1, 2.1, . . .) that reflects or is consistent with the corresponding principle. Please note that the numbered order of the principles below is not intended to reflect their relative priority.

Application: This model code is meant to apply to Arizona health care, public health, and emergency preparedness officials and practitioners in public and private sectors seeking to (1) plan, prepare, or respond to declared states of emergency or public health emergency in which the health of the public is at risk; or (2) implement a crisis standard of care as defined by the National Academies of Science Institute of Medicine (IOM).¹ These combined events are characterized in the text below by the use of the single term “public health emergency.”

The model code is not intended to apply to responses to localized emergency events of limited duration, state-wide emergencies that do not implicate the public’s health, or events that do not require critical decisions on the use of scarce resources to protect or promote the public’s health. In addition, the model code is intended to supplement, not supplant, relevant portions of existing codes of ethics and professionalism for health care practitioners, hospitals, hospice care, public health practitioners, emergency responders, or other relevant persons or entities.

Definitions of Key Terms:

Decision-makers: Persons tasked with making decisions regarding emergency responses or the allocation of scarce resources during a public health emergency on behalf of governmental bodies (e.g., federal, state, tribal, or local) or private sector entities (e.g., emergency response organizations, hospitals, health care providers, health insurance companies, or pharmaceutical companies).

Health care practitioner: A person that furnishes health care or public health services.

Health care provider: An organization or institution that furnishes health care or public health services.

Public health emergency: Either (1) a declared state of emergency or public health emergency in which the health of the public is at risk; or (2) circumstances that require implementing a crisis standard of care as defined by IOM.

1. **Duty to Care.** Health care providers and practitioners have a duty to provide care during public health emergencies.
 - 1.1. Duty not to abandon. Health care providers and practitioners must not abandon patients or others who have a reasonable expectation of care based on prior commitments and available resources.
 - 1.2. Duty to care despite risks. Health care practitioners are obligated to (a) provide care to the extent such care is effective and appropriate (see *Soundness*, below) even if doing so will expose them to greater than normal risks to their own health and (b) avail themselves of relevant and available protective measures. A health care practitioner’s duty to care is

balanced against reciprocal ethical obligations that society and institutions owe practitioners (see *Reciprocity*, below), as well as against competing ethical obligations practitioners may have to their families or others to whom they owe a duty of care.

- 1.3. Duty to provide comfort care. Patients who are ineligible to receive limited allocations of scarce preventive, life-saving, or life-sustaining resources or services for any reason should be offered available forms of curative and palliative treatment or services.
2. **Soundness**. To the extent possible, responses in public health emergencies should be consistent with known or empirically-supported “best practices.”
 - 2.1. Effectiveness. Responses should be demonstrably effective and based on existing data or known efficacy.
 - 2.2. Priority. Responses should prioritize protecting the public from preventable causes of morbidity and mortality.
 - 2.3. Non-Diversion. Essential emergency resources should not be diverted to address non-emergency conditions.
 - 2.4. Information. Decision-making should be based on solid, well-informed situational awareness, be coordinated with others involved in the response, and limit, as much as possible, *ad hoc* decisions.
 - 2.5. Appropriateness. Decision-makers should be duly qualified (or consult with those who are qualified) to understand and assess public health and ethical consequences and alternative courses of action.
 - 2.6. Risk Assessment. Responses should undergo risk assessment when possible to avoid creating additional undue risks to others or undermining response efforts to the greater harm of the larger community.²
 - 2.7. Flexibility. Public and private sector decision-making processes must be flexible and revisable to reflect current information based on the prevailing and emerging circumstances.
3. **Fairness**. In a public health emergency, similarly-situated individuals and groups should be treated in similar ways.
 - 3.1. Consistency. Decision-making criteria and methodology should be applied consistently across settings, populations, institutions, and jurisdictions.
 - 3.2. Justice. Public health responses and allocation of scarce resources (such as vaccines, ventilators, or evacuation assistance) may not be based on factors unrelated to health status and emergency response needs. Impermissible factors include, but are not limited to: race, gender, ethnicity, religion, social status, location, education, income, ability to pay, disability unrelated to prognosis, immigration status, or sexual orientation.
 - 3.3. Medical need and prognosis. Allocations of scarce medical resources should prioritize individuals or groups with greater medical needs, based on their medical prognoses, likelihood of positive medical response to available treatment or services, relative risk of harm posed by withdrawing or withholding treatment, and other indicia of survivability.

4. **Reciprocity.** Those who face disproportionate burdens for the benefit of the community in public health emergencies should receive additional support.
 - 4.1. Protections for individuals. To encourage compliance with voluntary public health restrictions (such as quarantine, social distancing measures, or disease reporting), affected individuals' compliance should be recognized through measures that protect them from job loss and negative repercussions due to immigration status.
 - 4.2. Protections for essential personnel. Health care practitioners, emergency first responders, and others who perform essential emergency functions should receive priority for protective measures in limited supply (e.g., vaccines or protective equipment) and should receive other protections or services (e.g., childcare services, workers' compensation coverage, or limited liability protections).
 - 4.3. Protections for essential providers. Additional support and resources should be allotted to health care providers that take on disproportionate financial or logistical burdens as part of emergency response efforts.
5. **Proportionality.** The least restrictive means should be used whenever possible during a public health emergency, reserving restrictive measures only for when they are essential to effective response.
 - 5.1. Balancing obligations. Decision-makers should balance obligations to protect community health with respect for individual liberties and other interests. If more than one equally effective option exists, decision-makers must choose the option that poses the fewest risks to individual liberty, privacy, justice, or other legally- or ethically-grounded rights.
 - 5.2. Limited application and duration. To the fullest extent possible, consistent with public health purposes, restrictive measures (e.g., isolation, quarantine, curfews, or other social distancing efforts) should be voluntary and imposed only if it is determined that other public health measures are insufficient or unavailable. Restrictive measures must be limited in duration and should not be continued after significant risks to individuals or the public's health have abated.
 - 5.3. Well-targeted. Restrictive measures must be well-targeted to apply only to individuals or groups in the population who must be restricted to avoid significant risks to the public's health.
 - 5.4. Privacy. To encourage compliance with recommended screening programs and other interventions, decision-makers should respect individual and group privacy and confidentiality expectations. The rationale for sharing identifiable health or other data to protect the public's health should be clearly communicated.
6. **Transparency.** Policy decisions and their justifications prior to and during public health emergencies should be open to the public with opportunities for public consultation and input.
 - 6.1. Public engagement. Plans for public health emergency responses, including specific methods for allocation of scarce resources and decisions regarding any limitations on personal liberties, should be made available to the public. Public input and comment

should be solicited and considered to the fullest extent possible consistent with public health purposes.

- 6.2. Openness. Decisions that affect the public should be communicated openly, honestly, and thoroughly.
 - 6.3. Communication systems. Decision-makers should use multiple, available, and effective communication systems to consult with various relevant stakeholders and the public.
 - 6.4. Documentation. Decisions should be documented to the fullest extent possible.
 - 6.5. Full disclosure. Emergency responders should be fully informed of the risks prior to participating in the response and informed of developing risks to the maximum extent possible.³
 - 6.6. Accessibility. Decision-makers should communicate vital information in a way that is accessible to those of different ages, disabilities, and linguistic abilities to the fullest extent possible.⁴
7. **Accountability**. Decision-makers and individuals are responsible for their actions (or failures to act) in a public health emergency.
- 7.1. Individual responsibility. Individuals are responsible for their decisions to comply with emergency response orders or recommendations. Those who choose not to comply with public health emergency measures (e.g., evacuation, quarantine, or vaccination) may lose access priority for future aid to the extent the need for such aid stems from their prior decisions.
 - 7.2. Duty to evaluate. Decision-makers should monitor the effects and evaluate the efficacy of decisions and responses implemented.⁵
 - 7.3. Public accountability. Decision-makers are accountable to the public for failures to abide by applicable crisis standards of care or the principles and standards articulated by this Code.
8. **Stewardship of Resources**. Scarce resources must be managed during a public health emergency to prevent morbidity and mortality to the greatest extent possible while maintaining respect and care for individuals.
- 8.1. Duty to plan. Decision-makers must plan ahead and develop affirmative, advance guidance for health care providers, health care practitioners, emergency responders, and others involved in the emergency response.⁶
 - 8.2. Triage allocation plan. Decision-makers must develop an advance triage allocation plan for scarce, essential resources that is consistent with the principles and rules of this Code.⁷
 - 8.3. Specificity. To ensure that guidance on resource allocation is most effective, uniformly applied and comprehensible, guidance should be as specific as possible.
 - 8.4. Duty to recover and restore. Decision-makers must develop plans to recover and restore resources mobilized during the emergency.

¹ INSTITUTE OF MEDICINE, GUIDANCE FOR ESTABLISHING CRISIS STANDARDS OF CARE FOR USE IN DISASTER SITUATIONS (Bruce M. Altevogt et al., eds.) (2009), *available at* <http://www.iom.edu/Reports/2009/DisasterCareStandards.aspx>.

² For example, in Arizona's 2011 National Level Exercise, "Vigilant Guard," the exercise scenario called for health volunteers to self-report to hospitals in response to a nuclear blast. However, no risk assessment was done or guidance provided on safe driving routes to the hospitals, which may have placed healthy volunteers in the pathway of a fall-out plume. Failure to conduct adequate assessment in the call for volunteers could have increased morbidity and mortality in the community.

³ For example, in a 2011 plane crash at a Reno Air Show, Medical Reserve Corps volunteers were called to assist with the response but were not informed or prepared for the gory nature of the response scene. The lack of preparation had a negative effect on the responders following the incident. Full and open disclosure of the nature of the incident and the advanced provision of mental coping strategies would have been beneficial to the responders.

⁴ This standard is modeled after standards of the Head Start Program, the Americans with Disabilities Act, and other programs that provide that invasive measures that impact the health and well being of children, the disabled, or those who otherwise may not understand what is being asked of them should be informed to the extent possible through appropriate direct messaging or guidance for care-givers on how to speak to those affected about measures or actions that will impact their lives.

⁵ The duty includes an obligation to ensure follow-up services are made available to health care providers, health care practitioners, emergency responders, and others involved in the emergency response, to the extent appropriate and necessary. For example, in a training exercise, large volumes of local volunteers who played victims of the emergency event were not afforded restrooms, water breaks, etc. Following the event, volunteers experienced adverse effects from participation, but were not screened or provided guidance on first aid or follow-up home care.

⁶ For example, plans should be made for handling spontaneous volunteers and donations. Unused volunteers and donations may consume scarce resources on site until they are integrated into the response. Advance plans should include resource pathways and anticipate use of offsite staging areas to manage the intake at the receiving facilities to maximize response effort effectiveness.

⁷ For example, in the 2010 Haiti earthquake and 2011 Arizona National Level Exercise, "Vigilant Guard," although the immediate need for health personnel, equipment, water, and supplies were identified, prior plans had not included supply-chain delivery in the priority planning for incoming flights. The lack of available airports and planes exacerbated scarcity in the supply chain. A resource triage allocation plan developed in advance by decision-makers may help avoid first-come first-served scenarios and reactive restrictions beyond what is necessary.