Ethical Issues
In Disaster Relief
Raised by Surgeon

By T.F. Dagi, M.D.

As an observer of the recent earthquake in El Salvador, and a participant in the rescue efforts that followed, I became aware of several important ethical issues in international disaster relief. Although international health policy in general has been examined in a variety of ethical contexts, this particular aspect has not. Facets of the interaction between the nations and organizations offering assistance and the recipient country are reminiscent of the relationship between a physician and a critically ill patient. This essay examines the analogy.

After the earthquake, the medical system of San Salvador was severely disrupted. Two of seven large hospitals were structurally unsound, and four others were largely unusable. Emergency supplies were inaccessible. Power, water, sewage and telephone and radio communications were interrupted. Health workers were torn between conflicting responsibilities to existing patients, to earthquake casualties and to their own families. In addition, the threat of guerrilla attack was ever present. The situation was further complicated by warnings that a second major earthquake was imminent.

The statue of El Salvador del Mundo, the patron of El Salvador, was decapitated by the earthquake. As a result, fears of supernatural retribution swept the barrios. People slept in the street and were reluctant to reoccupy hospitals, even those that appeared structurally sound.

Professional damage assessment teams arrived within 24 hours as part of the international relief effort. The physical damage appeared more limited than initially suspected. Because of the light roofs and open construction of Central American houses, the number of injuries was proportionately smaller than in the recent earthquakes in Mexico City or Columbia. Through tremendous effort and ingenuity, hospital staffs contended successfully with all the casualties. In-hospital mortality was extremely low even though ideal principles of disaster management could not be respected fully.

It was the outside consensus that virtually everything, with the exception of specific technical expertise, was available in El Salvador or could be improvised. The Salvadoran government, in contrast, convincingly argued that experts from donor nations had underestimated the devastation by ignoring the influence of psychological factors. Government spokesmen contested the conclusion that indigenous resources were adequate, and requested that hospitals, medical and rescue supplies, blankets, tents, generators and heavy earth-moving equipment be delivered as quickly as possible. The government, as it turned out, was substantially correct: the number of homeless, for example, had been underestimated by at least 50 per cent.

The humanitarian aspects of every disaster response are complicated by a number of pressing issues. Divergences of perception between outside experts and the host country, for example, invariably lead to questions about what and how much to provide, to whom and through whom. How should expert technical reports be evaluated in the light of official government statements? Disaster experts often focus specifically on the first few days after a catastrophe, while governments legitimately look beyond initial relief to later stages of reconstruction. Is there an obligation to verify that aid reaches the designated beneficiaries? In El Salvador, the government created a private watchdog committee to track the distribution of emergency aid and avert any hint of corruption or misappropriation. In Mexico (1985), and in Managua (1965), where such safeguards were not established, real and alleged abuses resulted in far-reaching political instability.

Are such situations best resolved by recourse to the "trickle principle?" It is often postulated that supersaturating the economy with necessities, will allow sufficient quantities to trickle down to the population at need despite failings in the distribution system. Is it ever fair to use disaster relief as an instrument to induce the host country to change certain attitudes or policies? Aid in other circumstances is often used as an instrument of foreign policy. Finally, because there is always an unstated competition between countries and organizations providing aid, the image of eager generosity may be politically advantageous to some countries or agencies with secondary agendas. How influential should such considerations be in determining the scope of the rescue effort?

I have proposed an admittedly imperfect analogy to physicians treating a critically ill patient as a model for discussing these issues. Countries devastated by natural disaster and critically ill patients share several characteristics. Both turn to outside experts for advice and assistance. Both are prone to combinations of overstatement and denial depending on previous history. Both tend to develop powerful dependencies that can prove useful or destructive: e.g., the dependency of a smaller power on a greater one may be construed, in the absence of political or cultural parity, as a political debt that (continued on page 2)
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can be called in at any time. The complexities of this dependency is analogous to processes of transference and counter-transference that interweave physician-patient relationships. In consequence, both nations and patients risk compromising their autonomy: disasters, like illness, limit the range of acceptable choices. In both situations, trust is a very precious and volatile commodity. In both settings, the donor and the recipient may have different perceptions of needs and values. Finally, the recipient in both circumstances permits activities that might otherwise be interpreted as invasions of privacy or sovereignty.

Ethical principles pertaining to the doctor-patient interaction are also germane to disaster policy. First, the principle of autonomy applies equally to patients and, when reformulated as principles of sovereignty and self-determination, to nations. Uninvited intervention carries the risks of adverse publicity, international rebuke, and, on some occasions, war. Second, the principle that justifies restrictions on individual autonomy to prevent harm to others (the “harm principle”) probably extends as well to nation-states, though the ramifications of violating national sovereignty are more complex than the ramifications of violating autonomy. Third, paternalism has suffered the same condemnation in international relations as it has in conducting clinical interactions at the bedside. It is particularly difficult to separate weak paternalism from the harm principle in this setting.

The principles of beneficence apply to individuals, nations, and in particular, to international relief agencies, for whom they should arguably become the operant rule. The use of these principles leads to two initial conclusions: relief efforts are morally desirable and may at times be obligatory; and host sovereignty ought to be preserved. Admittedly, a request for international disaster assistance may evolve into a limited compromise of sovereignty, somewhat akin to the treatment in maritime law of vessel salvage. But like a patient undergoing treatment, no country intends to surrender its sovereignty or autonomy indefinitely.

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These principles must then be reconciled when there is reason to believe that the host government has failed to act responsibly, whether by mistaken or deceptively representing its needs, by neglecting to provide for fair and equitable distribution of relief, or, in the extreme, by functioning outside its legitimate authority.

(This essay represents the personal views of the author and does not reflect the opinion of the U.S. government or any of its agencies. Dr. Dagi is attached to the neurosurgery service of the Walter Reed Army Medical Center.)

Books

Recent Acquisitions

(New additions to the collection of the National Reference Center for Bioethics Literature)


Callahan, Daniel; Caplan, Arthur L., and Jennings, Bruce, eds. APPLYING THE HUMANITIES. New York: Plenum, 1985. 329 p. (The Hastings Center Series in Ethics.) Seventeen essays discuss the practical use of the humanities in the context of medicine, social sciences and public policy.

Meinke, Sue A. SURROGATE MOTHERS: ETHICAL AND LEGAL ISSUES. Washington DC: Kennedy Institute of Ethics, 1986. 6 p. (Scope Note 6.) The latest Scope Note from the National Reference Center for Bioethics Literature annotates 27 documents and lists 15 other relevant articles. There is also an introductory essay describing the bioethical and legal issues of surrogate motherhood.


(Marlene Fine and Doris Goldstein)
Rights, Beneficence Offer 2 Approaches To Fetal Dilemma

The following case study, one of a periodic series beginning in this issue of the Kennedy Institute Newsletter, was written by L.B. McCullough.

Case Report

Ms. S is a 32-year-old lawyer married to a 34-year-old executive. Ms. S. is pregnant for the first time. Because of abnormal fetal growth and ambiguous findings by ultrasound, Ms. S was referred by her physician to the perinatal center of University Hospital for further evaluation. Following a complete workup, including extensive ultrasound evaluation, the perinatologist reports to Ms. S a diagnosis of fetal hydrocephalus with macrocephaly, but with no detectable associated abnormalities such as spina bifida or encephalocele. The perinatologist explains to Ms. S and her husband that isolated fetal hydrocephalus with macrocephaly results in an increased incidence (about 30 per cent) of mental retardation and an increased risk of early death. He also informs them that associated abnormalities may have gone undetected. He points out as well that there is the potential for normal or even higher than normal intellectual function.

The perinatologist then explains that there are two ways in which delivery can be managed. The first maximizes outcome for the fetus. Delivery is performed by Caesarean section, after which the infant's hydrocephalus is managed surgically. The Caesarean section carries very small mortality risks for the woman and small but manageable morbidity risks—both for this and future pregnancies, which will also most likely have to be managed by Caesarean section.

The alternative, cephalocentesis, followed by vaginal delivery, greatly reduces maternal risks of mortality and morbidity, but increases them very considerably for the fetus. This procedure results in decompression of the fetal head, allowing vaginal delivery, but involving a fetal mortality rate of close to 100 per cent. This procedure is sometimes performed with the intent of destroying the fetus.

Ms. S and her husband say they want some time to think the matter over. They return to their obstetrician a week later and request that cephalocentesis followed by vaginal delivery be performed. They are concerned that the child they might have could experience severe mental retardation, would undergo the risks of surgery and might die early. They say they do not see how such a life would be worth living. In addition, they have concluded that they want to avoid the burdens of raising a handicapped child. They also contend that they would not be able to give a handicapped child the time and attention it would require.

How should their obstetrician respond to their request?

Comment

One approach is to ask whether the viable fetus has the right to be delivered by Caesarean section and thus whether the obstetrician has the obligation to recommend this course. If one takes seriously the ethical theory that only persons—i.e., rational, self-conscious entities—have rights, then this case is fairly easy to resolve. Either the viable fetus is not a person (in a philosophical not a legal sense) and hence has no rights, or is only a potential person without the rights of persons in a strict sense. On either account, Ms. S.'s right, as an indisputable person, to control what happens to her body wins the day.

However, rights-based accounts of ethical issues in the intrapartum management of pregnancy are not the whole of the ethical story. Even if one does not think of the viable fetus (continued on page 4)

K.I. Doctoral Fellow Wins Fulbright Award

Maura O'Brien, a doctoral fellow at Georgetown University's Kennedy Institute of Ethics, has been awarded a Fulbright Postgraduate Student Award to conduct research on her dissertation, "AIDS, Ethics and Public Policy: Balancing Individual Rights and the Common Good," at the Centre for Human Bioethics of Monash University in Australia.

Ms. O'Brien's project focuses on fundamental issues in the development of AIDS public policy: To what extent, in a pluralistic society, may individual autonomy be restricted to promote and protect the public health? In formulating AIDS policy, how may the state marshal a response while protecting the rights of the disenfranchised groups that have been most affected? How do we as a society express our moral commitment to the principle that all persons should be treated with compassion and respect? Using AIDS as a case study, Ms. O'Brien seeks to identify a viable role for ethics in the public policy process in the United States and Australia. She hopes to broaden the scope of her research to include Western Europe and Canada.

Ms. O'Brien initiated her study by examining ethical and policy issues relating to AIDS in the workplace. As an associate for ethics at the New York State Task Force, a 25-member commission mandated by Governor Cuomo to address the ethical, legal and medical issues engendered by scientific advances, Ms. O'Brien continued her research on AIDS policy in New York State. While in Australia, Ms. O'Brien will film a documentary video on ethical and policy issues in AIDS. The video, funded by SELF Magazine and Chrysler Corporation, will be used primarily for educational purposes.
Roundup

- A conference titled Mental Retardation: Research Accomplishments and New Frontiers, was held at the National Institutes of Health on Nov. 17-19. Leading clinicians and researchers in the field described some of the progress that has been made in recent years toward the prevention and treatment of mental retardation. They also speculated about a range of possible breakthroughs that may one day allow mental retardation to be cured or prevented at the genetic level. Eunice Kennedy Shriver, executive vice-president of the Joseph P. Kennedy, Jr. Foundation, was the featured speaker on November 17. Her topic was “25 Years of Accomplishments in Mental Retardation Research.” That evening the Kennedy Foundation presented its International Awards in Mental Retardation and sponsored a panel discussion on ethical issues in mental retardation. The panelists were Drs. John Fletcher, Herbert Lubs and Julian Williams. They discussed the ethical implications for persons with mental retardation of genetic screening and human gene therapy.
- Fr. J. Bryan Hehir, a senior research scholar of the Kennedy Institute, was appointed the Stillman Visiting Professor of Roman Catholic Theological Studies at Harvard Divinity School, spring semester 1987. Father Hehir has also been appointed a member of the Center for International Security and Arms Control, Stanford University; associate, Harvard University Center for Science and International Affairs (1986-87) and a member of the International Advisory Board of the Institute for International Peace Studies, University of Notre Dame.
- Hans-Martin Sass of the Kennedy Institute has received a grant from the Bundesministerium fuer Forschung und Technologie, Federal Republic of Germany, in the amount of 65,000 Deutsche Marks for a project to study the implications of the U.S. Bioethical debate for public policy.
- A symposium on Pediatric Brain Death and Organ Retrieval will be held here on March 27 and 28. Scientific, theologic, ethical, legal and economic issues will be considered. For further information, write or call Howard Kaufman, Department of Neurosurgery, West Virginia University Medical School, Morgantown, W. Va., 26506 (304) 293-5041.
- “The Value of Many Voices,” a conference sponsored by the Center for Applied Biomedical Ethics and AMI/Presbyterian/Saint Luke’s in Denver, will be held February 11-13, 1987. It will explore how cultural, religious and social value differences complicate ethical decision making. For information please contact the Center for Applied Biomedical Ethics, 4567 East Ninth Avenue, Denver, CO. 80220. Tel. (303) 320-2895.
- Concern for Dying is offering an accredited training program for physicians, nurses, social workers, attorneys and allied health professionals: “Death Dying and Decisionmaking: Psychological Care of Patients and Families” on March 6-9, 1987 at Seabrook Island Conference Center in Charleston, S.C.

Case
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as a person, one might regard it as a patient to whom the physician and perhaps the pregnant woman owe weighty obligations founded in the principle of beneficence. The principle applies clearly to the fetus in this case: Its virtually certain death from cephalocentesis followed by vaginal delivery can be prevented and its handicap condition can be ameliorated by means of a low-risk (for the fetus) mode of delivery and a surgical procedure with manageable risks as the price for improved outcome.

In a beneficence-based calculus the risks to Ms. S. of Caesarean section are significantly less weighty: the risk of death is very small and the morbidity risks are manageable. It may also be the case that a woman who continues a pregnancy until the fetus becomes viable implicitly binds herself to these beneficence-based obligations. Thus the woman’s ethical obligations to the viable fetus seem parallel to those of the physician. On this account, the physician should not accept Ms. S’s request and should try to persuade her and her husband to change their minds.