Speaker: Hello, everybody. Oh, the mike is working. Thank you so much. It is a beautiful day. I wish we could just step outside, but I have some pictures to show you, and for those of you who read the book and know that there are no photographs in it, maybe you'll like to see those, and I just want to also say what an honor it is to be among you today. I don't travel that much now that I have a full-time job, but when this invitation came in I really was very eager to speak with you, and I think what you do is truly important. And we're going to talk about some very difficult situations, difficult decisions, not only amongst the front-line nurses at the hospital in New Orleans that I'm going to discuss today, but also among the people who took part in trying to make sense of what happened there, trying to investigate, get to the truth of what happened, and then try to apply some sort of judgment to it, I guess is the best word, and that was a really, really tough situation, too, and there were nurses, nurse investigators involved in that.

I also want to recognize that there are people in the audience who come from areas of the country that were affected by this disaster as well as others, but in particular, and so I look forward to really rich discussion at the end, and I just want to acknowledge them and their service at really a time of national catastrophe. With that said, as you know, you and your colleagues have worked hard to achieve the awesome responsibility of serving the ill, of healing, and times of crisis are times when we can really shine as health professionals, but there are also times that really try us. In that first book, [inaudible 00:02:14] Bosnia," was my first time when I went overseas and I saw just how… I think sometimes we have this romantic vision of war or of disaster, and even in the NATO war surgery manual,
the frontispiece says something about "the blood of battlefield is critical for the rearing of good surgeons."

There's the idea that -- and it certainly does, and we see it over and over again -- the heroism, the way that we rise as humans to these very difficult and trying situations, but of course these situations also really test us as professionals. They test our ethics, our professional standards. Ethical principles that we find are hard enough to apply every day sometimes conflict with each other in a disaster. These are really tough times for adhering to the highest standards of the profession, and we'll talk about that today. The point of today and the point of the book really is to think in advance about how we might handle the most difficult situation before we face them, and in that spirit is why I wrote the book, because I think -- and this is not necessarily just for front-line nurses or front-line doctors, but really for all of us as citizens, because any of us could end up in a disaster, and what I've seen just as an aid worker and as a journalist is that really it is the people in the immediate vicinity of the crisis that can really make a life-and-death difference in that early critical phase, so it really is for all of us to think about these things. Just like a person who plays sports practices and envisions before they go through it, that's the ideas, thinking through the worst case before we ever have to face it can put us in a little better position, and these people who we're going to talk about today were really stuck right into a disaster that they didn't' have that benefit that we have.

I think the greatest part of humanity is that sometimes we get through these difficult situations through humor, and we've all seen that, so I'm going to start out with a little humor because you all showed up today and didn't go off into the sunshine, so this is how Jon Stewart makes sense of hospital preparedness:

Actress: You're in a flood zone. Are the generators in the basement?
Jon: Yes. That's where we keep our generators.
Actress: But with your feet.
Jon: So you come in there and you're like, "I'm having a heart attack, where are your generators?" They're like, "They're in the basement!" You go, like, "[inaudible 00:04:53]!"
Actress: Take me to the next place!
Jon: All right, well, what's the weather going to be for the next two days?
Speaker: So it really is easy to feel a little defeated by just the larger infrastructure challenges that we have, but again that message is that we can really make a difference, and by the end of the discussion I'll give you examples of how quick thinking and creativity have really played a role at saving a lot of lives. Just to start out, I want to bookend the talk by introducing a little more recent example of a
disaster that happened in my current city where I live, New York City, and that's Hurricane Sandy.

We had the storm that was coming in and a lot of our health care infrastructure is along the water. Our nursing homes, because people like to retire and look out at the sea, so there was a raid on the Rockaways. It was also cheaper land, I think, when they built those places, and so as the storm surge approached, as high tide approached, even though there had been a general evacuation of the city of the vulnerable areas of our city, the nursing homes, the hospitals -- the public health leadership had encouraged the heads of nursing homes and hospitals to shelter in place with a few certain things, like move everybody up to the second floor, try to move your ventilator-dependent patients out of the way, make sure your generators turn on.

They went and checked that. They eyeballed the generators, but if they were sitting in the parking lot right by the ocean, they still allowed those places to shelter in place, and so what happened was that as the storm approached and it became clear the storm surge predictions got worse and worse, and you run out of time to evacuate at some point. To do a major medical evacuation is a time-intensive and obviously a risky thing. Of course, the idea of keeping them in place was that there's a risk to moving people.

Then that was when people started to think about the worst case scenario, and this is a couple of physicians, a physician and an administrator from one of the hospital chains in New York City, and they were kind enough to let me sit in their command center as they handled the storm, and they had many different facilities, two major hospitals, which were in danger of losing power because their electrical system was vulnerable.

And it was only in those last hours that they called up those places and they said, "Have you guys gamed out what you would do if you lost all power?" It was amazing, years after Katrina, to think it's just... I think it's just a human thing, it's hard for us to think through what, in a modern American hospital, would we do if we lost all power?

But I think the point is that if we have these vulnerabilities, we have to think about this beforehand. In any case, they were in this scenario, and what happened was that the medical head of the ICU, a physician, was called at another hospital into the command center of Bellevue hospital, which is our big, big public hospital, sits on the East River. At that point, the basement of Bellevue was filling up with what would end up being millions of gallons of floodwaters, and this is a picture I took during the disaster at Bellevue, where I went after, and this is jerry-rigging going on.

What this doctor was told that "we think our power's going to fail; however, there's this auxiliary generator in the administrative building next door. We think that's
better protected. We think we could get six power outlets on your ICU to keep working," and she had 50 patients in her ICU and they literally said to her, "Doctor, we need a list." So, six patients. Just think about that. Six outlets, 50 patients. How would you even begin to make that choice of that prioritization? I'm going to come back to that at the end of the discussion, but putting us in mind of this idea that in disasters, often we face these situations that are really something that goes back to the time of Aristotle, this idea that how do we decide who gets the goods of society when we don't have enough to go around? And frequently in disasters there are these conditions of scarcity, or at least perceived scarcity, and we face these choices, these awful triage choices, that are a very big extension from what we're used to in this country facing on a daily basis.

Let's go to now Memorial Medical Center, which was originally known as Baptist Hospital when it was founded in 1926 in New Orleans, and this is just a picture of the old hospital. I thought you'd like to see this picture in particular, which is that as part of its foundational...its founding documents, it had to operate a nursing school as well. That was considered really a fundamental part of this hospital's beginning in 1926.

The hospital was a really well-regarded community hospital, and over the years it had changed a bit. It was a Southern Baptist hospital, and then it, I think in the '90s, merged with another faith-based hospital, and then ultimately was sold to a for-profit hospital chain, Tenet Healthcare, and that's who owned it, and its name had been changed to Memorial Medical Center. The Southern Baptists have an amazing library, and I was able to get a lot of historical documents about the hospital and its founding from them, which was really helpful in piecing back together the story.

Ultimately what happened was, as you well know, in 2005 Hurricane Katrina struck New Orleans, drowning one of America's most beloved cities, and this is just a view of the same hospital. That's actually that same old part of the hospital was still in use, but of course it had many additions over the years, and what happened was the first day the storm hit and the waters had not risen at that point, and the hospital had a few vulnerabilities, one of which was that its backup power system was not configured to run the air conditioning.

As you can see and you can imagine, in New Orleans in August, the sun comes out after the storm, it soon became very, very hot. This is a vulnerability a lot of American hospitals have, and we've seen it in other disasters, that they're not required, even with these new regulations that CMS has put out -- the proposed rule a few months ago, some of you might know about this, that finally the federal government is proposing some standards around disaster preparedness. Even so, it's not necessarily clear that hospitals would have to retrofit and be able to run their air conditioning systems or their heating systems or ventilation in a
time of disaster, so that's a vulnerability. So it became hot very quickly, but they were running on backup power. They were managing pretty well. It was a day later when the levees failed and the water from Hurricane Katrina arrived at this part of the city that you saw this image and situation.

Now, the hospital had that same vulnerability that Bellevue did, which is that its backup power system was not protected against flooding, and they had actually had Hurricane Ivan a year before, I think it was, and it was a dry run in a way. It looked like it might hit the city, and the administrators took this very seriously and they actually sent one of their plants operations people out to some meetings that the Army Corps of Engineers had, and he carefully measured the different entrances at the hospital, the points where water could come in, and he determined before Katrina that if there were even four feet of water around this hospital, that the majority of the power would fail.

He had written a memo that he had actually gotten some estimates for what it would take to fix this vulnerability, and it was several hundred thousand dollars, and he said, "I'm going to file it away because I know we just don't have the capital right now," and this was just a few months before Katrina.

Knowing that they had that vulnerability allowed them to know they had to evacuate. As soon as they heard about the levee failure, as soon as the water started arriving, they decided, "We've got to get people out. We may have hours left before we lose all power," and so what happened was that helicopters began arriving and, as you can see, a lot of them were small helicopters, so they could take maybe one or two patients at a time.

Just to give you a sense, there were about 250 patients. There were about 2,000 people at this hospital at the time, and obviously nobody's going to drown -- it's an eight-story hospital -- but starting to think about how would you begin to prioritize those people with these little helicopters arriving. Just to give you a visual sense of the different people at the hospital, different groups of people, you have the little "neonates" in the NICU. There were about 20 of them, I believe, and this one is being cradled in the arms of a nurse's husband.

Everybody pitches in a disaster, so you had these really fragile "neonates." Then you also had very sick people, and you can see some of them here have been moved to staging areas where, underneath the helipad, was the parking garage, one of the parking garages, and so you can see that there's some really dependent patients that were in ICU. There was also a separately owned long-term acute care unit with some very, very sick people, about 50 of them. Multiple health issues, prolonged acute and chronic health issues, and a lot of them elderly.

Then, of course, as you can see, some people are sitting up in wheelchairs and you can see them also down here. This is the emergency room ramp, so you could imagine maybe wanting to prioritize some of the people who could sit up, and
maybe you could move them by boat. If you're thinking in a utilitarian frame, maybe some of those people would have a longer life expectancy, so do you want to prioritize them, or do you want to take the people who are more fragile and would need power, because your imminent crisis is that the power's about to fail. There were also family members, both of the staff as well as patients, and you can see the hallways were just filled with people and belongings. There were people boating up or floating up on various mattresses, canoes. This is a slightly more shallow area, but the water around the hospital ultimately got to about five to six feet, but still there were people coming up, and then you can the clinicians and the administrators arguing about whether these people should be allowed in, whether the hospital and its sacred role of serving the community -- particularly in a time of crisis -- whether this was still valid.

There were nurses, there were doctors, there as food, there was water, so should they take them in, or was this a dangerous hot shelter where they were trying desperately to get people out of, and therefore they needed to tell people to keep going? Dry ground was about eight blocks away. This was another debate. You had the staff themselves -- some of them were hot and some of them had health problems.

Of course, as you may know, nurses and doctors were in short supply after the disaster, and you always want to think about these resources, the precious resources, human resources, and should some of them be prioritized? Because you would need their work so much after the disaster. There were children of the staff members, so healthy children in this hospital, and there were even the staff members' pets.

Some of you who are not from hurricane-prone areas of the country might wonder what the pets were doing in the hospital, but in fact if you want to encourage willingness to report to duty in a disaster, you have to think about people who might have to leave a pet at home, might have no one to take care of it, and might be away for several days. As I was told, the head of medical records was a pet lover, and so she would also convert medical records into a kennel and allow the staff to bring their pets so they didn't have to leave them at home.

Sometimes when I open this up to discussion and I ask people, "Who would you prioritize if you were asked?", you'd be surprised at how many people raise their hands and say the pets. I say, "Why the pets?", and they say, "Because they're cuter than humans," or "they're nicer than some humans," but of course I'm sure none of you would put the pets over the patients, or maybe...

In any case, this was a tough choice, and then of course there's another question, which is who makes this choice? In this case, what happened was a small group of doctors were pulled together and had to make this decision on the fly. They decided to prioritize some of the ambulatory patients at first because they were
able to get a couple of National Guard trucks which had actually been stationed at the hospital for the storm and drive them out before the water got too high. They chose some of the dialysis patients, who of course would be very vulnerable without clean water supply and power about to go out. You can see them loading up the trucks, and then they also set a triage priority. They got the ICU patients out. They also got the NICU babies in that initial effort, and the helicopters arrived to do that, but they came up with a triage plan over a day, and the ones were the more ambulatory patients like these, so they gave them numbers, the ones.

The twos would be your more general acute care hospital patients, and the threes, like this gentleman here, if you can look on his gown -- and again he's been moved to a staging area in that parking garage -- the threes were the very sickest of the patients and also patients in particular who had "do not resuscitate" orders. The doctors decided this. There was no debate about it, the ones who I interviewed told me it was made and everybody agreed with this, and I asked them why they made this decision.

One of them told me, "I figured a patient with a DNR order would have a terminal or irreversible condition." Actually, in Louisiana, that's not required, but his perception was that they generally did, and that they would have "the least to lose" if everything failed compared with other patients. That is a value judgment, really, as much as a medical or nursing judgment, and then another doctor said, "Well, I figured that if the patient or the patient's family had made this end-of-life preference known to the doctors who put the DNR order on, that they wouldn't want extraordinary measures extended to them at the end of life." He figured that, by implication, they wouldn't want to be saved at the expense of others.

Of course, again, there's nothing in a DNR order that says this, as you know. DNR's no CPR, don't restart my heart if it stops, maybe don't put me on a ventilator, and so what happened was that this decision was made in the best of faith, in the best idea that they had at the time, but it wasn't really communicated directly to the families, and there were many patients who had family members, and as they started to hear rumors, as they started to notice, "The nurse said my mom was going to go out first because she's really sick. Why is everybody else being moved out of this ward besides her?"

Slowly they found out, "Well, she's got a DNR order, and the DNR patients would be put last priority," and you had these scenes where patients were literally begging their nurses, the family members begging their nurses to get a doctor to rescind the DNR orders. In some cases this was done. In others, it wasn't. This is some of the breach of faith that starts to happen between the people who are put into the position of having to enforce decisions, and then the families who are desperate. There were all sort of scenes, even about loading people onto
helicopters where you had to separate family members, and this was really, really tough for the nurses who to serve. 
There was also this fact that in this early, early push to get patients out before the power failed, all of those patients on the long-term acute care unit were not discussed in this first meeting, and so they just weren't even considered, and so all of them were still there after that first push to get everybody out that first night. What happened was that in fact that night the power did fail. Early hours of Monday morning was when the storm hit, early hours of Tuesday morning was when the waters rose, early, early hours of Wednesday morning all power failed, and you can imagine what the scene was like at that point. You had gunshots being heard outside the hospital. People didn't know how to interpret that. There was a lot of panic.

People were tuning in -- there was one radio station that was still broadcasting, and some of the nurses had...on their carts they had battery-powered radios, and I actually was able to get the audio and listen through to all the days of that diet that they were listening to and then sharing with their friends. There were so many rumors going on. People were calling in, and there were several points in the audio where they just referred to the people of New Orleans as zombies slowly wandering.

You had a public official who called in and reported that a shark was in a hotel swimming pool, or it might not have been a shark. It might just have been a piece of debris that looked like a shark, he wasn't sure. There was panic going on, and some of you probably remember just he outlandish or the outsized stories of violence, some of which turned out to be true, a lot of which turned out not to be true when we found out after the storm, but people inside the hospital were afraid, some of them.

Then you had the different levels of fear and people worrying, starting to divide along socioeconomic lines, along racial lines, fears along those lines as well in some cases. In other cases, people who worked at this hospital were very brave. A lot of the staff said, "I knew we'd get out, I didn't panic." It just really varied, and when you're in a disaster, of course some people are going to have had experiences that make them more traumatized, more easily traumatized, and sometimes you just don't know who's going to… Even ourselves, we don't know how we would react with no sleep, with heat, with rumors of violence, with perhaps loved ones outside the city that you desperately want to return to.

You might be a mom or a dad or have people who depend on you. So all these things were going on -- worries about their own homes, worries about relatives. You had all of this happening. You also had helicopters starting to come less frequently. There was a triage going on throughout the city. People were waving rags off their rooftops, begging for help. The people who were risking their lives to
the fly the Coast Guard helicopters with no air traffic control, completely dark city, landing on rooftops with power lines -- they had to make decisions. Would this person have any water? Could they have medical needs?

We have so many people who have home medical needs, probably that population who wasn't able to evacuate in this case. So they figured at least at a hospital there's medical staff. There's food, there's water, there supposed to be able to shelter in place for a time, so helicopters came more slowly. A day passed and these desperately sick patients became even sicker, as you can see just what that looked like and how hard that would be.

This nurse here is providing the best care that she can, and it's literally waving a scrap of cardboard over that patient to try to get a little air going because it's 90-some degrees outside, and as caregivers, as empathetic caregivers, some of them really felt desperate and felt they had lost the tools. We're so dependent on our tools, our modern tools, our electrical tools, and they felt powerless, some of them.

There are parts of the world, as many of you know, where medical staff, nursing staff have to practice in these kind of conditions frequently and they make do and they come up with ways to do that, for better or worse, but fortunately we don't usually have to practice this way, so this was a big drop, a big challenge for the health professionals who were stuck in this way.

Pets were not being allowed to accompany their owners on the boats that were coming up to help get people to dry ground, and a lot of staff started to ask the doctors if they would euthanize the pets, and the reason the pets weren't being allowed along was that you had 2,000 people in the hospital. You had these little air boats coming up, and there was the sense that don't even let people bring a suitcase, maybe a wallet, let alone a whole pet, and some of the pets started to be euthanized.

These sick people, as they grew sicker, some started to die, and there was a fear amongst the nurses and the doctors that others would not make it. What was to be done about them when it was time for everyone else to leave? And the question arose and it started to be discussed amongst the staff members. What about putting some of the patients out of their misery?

I just want you to stop and think about if you were working in a hospital or if you had to think about this after the fact, how do we make sense of this question? How would you answer that question? Of course we don't know what we would've done, but thinking through it, I think, is important.

What happened was that some of the staff -- and this is one doctor -- felt that the answer was the medicate these patients with the goal of hastening death, and he had a case which he bravely, I think, shared with me, which is that he had a patient up on the eighth floor, the ICU -- as I mentioned, they were evacuated first, but there were four DNR patients who were not evacuated in the first go-around.
He came up on that Wednesday, that day when the power had failed. He himself had had two heart attacks. He had to climb the eight stories to get up to the ICU in the heat, and he felt, "You know, I'm not going to get back up here." He saw four nurses caring for one remaining patient who was still alive at that time. She was a patient who had advanced metastatic ovarian cancer. Actually she was scheduled to be moved out of the ICU for comfort care to a regular ward, but then the storm hit and she had not been moved.

And he saw her, and a lot of things went through his mind, which was she had [inaudible 00:29:10], she weighed several hundred pounds. He wondered how the heck they could move her downstairs, given the lack of elevators. He thought that the nurses could be better used elsewhere, although it wasn't his job to tell them where to work, and he also thought she was getting comfort medicine, she was, he said, not responsive at that point, but he thought the worst thing he could imagine would be if she was moved and at some point woke up and found herself in this ravaged condition.

So he turned to one of her nurses, and he said, "Could you give her enough morphine until she goes?" And then he walked down the stairs, and to this day he feels he did the right thing for this patient. The nurse carefully documented the administration of multiple, multiple doses of morphine. I can't remember now -- it's in the book. She was getting a certain amount, and it was ten times or a hundred times that amount. It was just a huge amount that was given over and over again until she died a couple hours later.

And so that was what happened with that particular patient, Janie Burgess. Now, there were others in the hospital who disagreed, and this was one of them, Dr. Bryant King. He was a young hospitalist, just started working in the hospital, and one of his colleagues from med school came up to him and said, "There's this discussion going on about putting patients out of their misery. What do you think?"

And he said, "Are you kidding me? This is not a doctor's job! We take this oath!" This goes back, in fact, in the book. You read about the history of medical involvement in the bringing about of death and stopped at the time of Hippocrates, and it's something that we really, in this country, don't consider ethical. There's debates about assisted suicide, but really the idea of euthanizing, particularly without consent, is not considered ethical. That was his feeling.

As a physician he had been working among some of the sickest patients. He had examined them all. He was giving some of them -- the pharmacy was still working. Amazingly the pharmacists were sitting in the heat outside of the darkened pharmacy, and they'd demand a scrap of paper with a prescription, and then they'd go back in with their flashlight, get the medicine, and bring it out. So he had given patients benzodiazepine, small doses of morphine as needed. He felt that these
patients were not in the sort of discomfort that would require sedation, let alone
ercy killing, so he really opposed this idea.
He ended up -- when he saw some syringes coming out, when he saw what he
perceived to be this effort to medicate these patients which he believed was to
bring about death, he left. He refused to participate, but he left, and he was later
criticized for abandonment. Now I should point out there were other doctors and
nurses leaving at this time. There really were very few patients left, and it was a
time, ironically, when all of the rescue assets were finally focused on this hospital.
There was a great urgency about getting people out. There was this sense of danger
in the city, and so you had boats, you had helicopters finally landing, finally
coming, just as this decision was made to medicate these patients.
What happened was that ultimately -- I'm going to show a picture that's somewhat
disturbing -- this was the hospital chapel, and a photograph that was taken after the
storm and after the evacuation. The patients that died, they had been blessed and
placed in the hospital chapel and covered respectfully. What happened was that
when the disaster mortuary team, they recovered more bodies at this hospital than
at any similarly situated hospital in the city, and there were many hospitals that had
also had a similar situation: Loss of power, desperate scenes, evacuations.
There were 45 bodies recovered here. Ultimately, going back in the research that I
did for six years, about five of them had been in the morgues before the storm, so
about 40 deaths either during or after the storm. Then, very soon after the storm,
the life care staff -- they had talked with their administrators, their parent company
in Texas about what had happened, what they perceived had happened, which was
that some staff from the other hospital had come to their ward, told them they
needed to leave, that the patients who remained would not be evacuated and that
they were going to take over and that there was going to be what they believed was
intentional hastening of the deaths of these patients.
That's how they perceived it. They reported to their superiors. The superiors
decided that the legal best strategy would be to report that to the state, to come
forward before they were approached, and so they did that and they reported the
suspected euthanization, mercy killing, whatever you want to call it, to the state. At
the time, also some people who were uncomfortable with what they perceived had
happened also spoke to the media, so there were these rumors that something had
happened here.
There were also deaths at other institutions, notably a nursing home where many,
many patients had drowned, and so the state, through the the Medicaid fraud
control unit, launched an investigation, and there were many people put on to look
at all the deaths in all the facilities, and as part of that they did toxicology.
What they found in this place was that 20 patients had received morphine and
Versed, either a combination or one or the other, and just based on when their
deaths were documented to have taken place, all of these deaths except for the woman who I just mentioned, who Dr. Cook had asked to be medicated on the Wednesday, but on that Thursday there were 19 or 20 deaths, and the injections had taken place and all these patients had died in a very short time period. So there was this investigation that was launched, and not all of the patients who had died were teetering on the brink of death like Janie Burgess, the one who I had mentioned to you before. This is Emmett Everett. He was a 61-year-old gentleman. He had multiple medical problems, was on that life care floor, but he was conscious, alert, had fed himself breakfast that morning. He had asked one of his nurses, "Cindy, don't let them leave me behind, please. Don't let them leave me behind," because he was a four-patient room, the other three patients had already been taken off of the floor.

And the thing about him, as you can see, he's very heavy set, and he also was unfortunate. He had had a spinal cord stroke as a young man, and so he couldn't ambulate, and the people I interviewed, the people the state interviewed who participated in the discussion about him said that they literally concluded they just had no idea how they could get him down seven flights of stairs in a hospital with no working elevators in the heat, let alone up to the helipad, let alone would a helicopter even be able to take someone of his size, and they concluded that he could not be rescued.

He was one of the patients who received these drugs and died on that Thursday, September 1st. Again, Monday morning, storm hits. Tuesday morning, flood waters. Wednesday, no power. Just a day later, it was that desperate, and this is a picture of his family. He lived at home before he went to the hospital. Devoted wife -- that's his children and one of his grandkids who he was very close to. So, clearly had a value to his life, and they were really devastated -- his family -- when they heard about what happened. That's, almost to a one, every single family member who I talked about this with after, their perception wasn't that they felt that something merciful had been done for their loved one who was suffering, but they all, almost to every single one, felt that "my loved one, their life still had value, even if it was a short time left," that some effort should have been made to rescue them. "My loved one served society, served in the army," whatever it was, deserved that chance at surviving, and maybe that's just how any family would feel.

Then it came to this question of how do we make sense of these actions in the context of a disaster, and this is where people like you, people who have to have this really tough role of not only doing what I did, which is to research and investigate and interview people, but thankfully I don't have to draw a judgment about these people. In fact, I didn't want to. I wanted the reader to read and take
away what they will, draw their own conclusions and think really mostly "how
would I go forward, knowing the story, and making decisions in future disasters?"
But there were people who were faced with this question of prosecution, of
judgment, of sanction, and how do we even adjudicate these issues when they
occur in a context like this? Among them was the coroner, Frank Minyard. He had
been in this position for decades. He was an elected official. As you know, there's
different systems in the country. In New Orleans, they're elected coroners. He was
an OB-GYN by training, so he didn't even feel he had the tools to judge whether
these were homicides or natural deaths or something else, which was what he was
asked to try to figure out.
There was a bright young investigator and veteran prosecutor for the Medicaid
fraud team that struggled to understand the truth of what happened as well. They
spent nearly a year investigating. Their team included several nurses, and they
interviewed a great number of the nursing and medical professionals at the
hospital. They reached out to the Louisiana and Texas nursing boards for
information about some of the nurses, and other interesting aspects was that the
incident commander was also a nurse within the hospital's administration.
Several people who the investigators interviewed had said that this incident
commander, this nurse administrator, had suggested euthanizing patients, and I just
thought this might be interesting to you guys, because this leader, she insisted that
she had never meant to suggest. She had said something about the pets, "We're
doing all this to comfort the pets, you guys seem to care more about the pets than
the patients. Shouldn't we be doing more for the patients?" Her sense was that that
had been misinterpreted to suggest euthanizing the patients, and she insisted that
wasn't her intention, although many staff at the hospital viewed that...they felt that
that was what she was saying.
We talk about these things in euphemisms, so it's entirely possible that there were
communication misunderstandings, but despite that she made an argument which
might be interesting, which is she said, "Well, I'm a nurse..." She had this one
disagreement with one doctor where she was suggesting giving the patients drugs,
medicating the patients, and the doctor said, "Absolutely not. I will not
participate," a female doctor, "this is not ethical." So this nurse administrator told
the investigators, "I told her, 'Okay, that's fine. If you disagree, you disagree. Don't
order it. You're certainly the physician. You have to order it. You don't want to
order it, don't order it.' It's just like if I ask a physician, 'Can I give a patient IV
fluids?', and you tell me no. Okay, I don't do it."
She was saying it is the doctor's responsibility because they're the ones who
actually order the drugs. I thought you might find that interesting, this whole
question of... Even the nurse who Dr. Cook asked to medicate the patient, and
what is the nurse's professional role if the nurse, for example, doesn't feel that
comfortable with doing something like that, or feels it's unethical? Obviously I think that there are standards in the profession that allow the nurse to disagree, but I thought this was an interesting point that she brought up about the role of the doctor versus the nurse in a situation like that.

Interestingly, another nurse, the one who had cared for Emmett Everett -- the one who I showed you, and the nurse who he had begged not to leave him behind -- she had been probated by the nursing board just two weeks before the storm for exceeding the scope of her practice, and she had also in previous times been suspended. Her license had been suspended because she had been found positive on a drug screen for oxycodone, and she was let go by her previous employer several months prior to the storm, but when life care hired her, the background check just said the previous employer's not allowed to talk about any disciplinary actions.

So they weren't given any information about her past, and interestingly, per the nursing board, under the conditions of her probation she was supposed to be closely supervised, but during the storm, as often happens, you end up even practicing outside of scope of practice sometimes, and there are big debates about whether that should be formally allowed in a disaster. So she was not closely supervised. She was, by all accounts, heroic, kept working when other staff couldn't do it. She was working on her own, taking are of a lot of these very sickest patients left on that seventh floor.

Her daughter told me that her mom -- her adult daughter was with her, and said that there was open access to narcotics, and the woman actually gave herself some morphine to help her work through the storm, quite interestingly. After the storm and the trauma, she continued to struggle with substance use, was worsened by her guilt over this patient, Emmett Everett, who she had promised not to leave behind. Her nursing license was ultimately suspended, and she died of complications from her substance use in her forties.

Her daughter told me she wasn't the same after that: "She started drinking more and then ended up losing her license, just faded away basically. The one thing I can figure it was, she wanted to be a nurse ever since she was three years old, and I guess she felt like she failed because she told him, 'We're not going to leave you behind,' and she didn't have any other choice.'" She had been just basically told, "You have to leave, there's other people coming to take care of these patients. You have to go."

She was in the middle of rounding with her patients, and she literally was told to leave, assured that her patients would be cared for, left and never got over the guilt over Emmett Everett's death. After a year of investigating, the state arrested a Memorial doctor and two nurses for second degree murder, and one of their colleagues that the nurses also had to go before the Louisiana board of nursing. I'm
not sure if that's true, that might have just been a rumor, but nurses from another hospital were reportedly reported to the board of nursing for abandonment, that their hospitals were furious because some of the nurses in one hospital where you could actually drive out...that some of the administrators were angry that some of the staff left, and reported them to the board for abandonment.

It's really interesting. One of the ethicists I spoke with, he said that in a case like this, if you really were in that situation where you had no choice but to either abandon your patients or mercy killing, euthanization, whatever, in that case you could excuse either choice. The tragic thing about this case is that actually that wasn't the choice. There was help coming. People could stay in the hospital, even if they felt patients couldn't be moved, they could stay with them, but that wasn't in their minds at the time.

I think it's very hard to maintain what they call situational awareness in a disaster, which is the ability to see beyond what's in front of you. You're exhausted, you're tired, you're scared. You haven't slept, you're not making really the same decisions you would, and I think that people really perceived, in some cases, that that was their choice. There's also just this question of whether a time of crisis is a time where we can make exceptions to moral rules, or whether an exceptional time is a time when we need to hold even more deeply into our fundamental moral values, to our professional standards.

There was one ethicist based in New Orleans, a physician who said to me, "You know, I think that acts of compassion -- you look at a patient and you're a caring nurse, you're a caring doctor, and you just want to stop that suffering, and it's your suffering, too, in fact." You're feeling that, too, and that in some cases we need our standards. We need our professional standards to prevent us from crossing line, even out of compassionate reasons. He felt that standards are really important. Interestingly instituted medicine looked at disaster standards of care, and they've done a huge amount of work around the subject. How do we make these difficult triage choices in disaster? How do we incorporate values? How do we get the community involved and aware of these decisions before we ever go through a disaster, because that's critical, both for the ethical input, the value-laden input, as well as for societal acceptance of some of these tough choices so you don't have people panicking and not understanding why choices are being made.

They said even in a time of disaster -- they came out in their report, a lot of them veteran disaster responders -- and said that "we still don't feel that euthanasia is ever something that we should say is okay in a disaster, even in the worst of times," and they also said that DNR orders shouldn't be used as triage criteria, because that's reflecting good end-of-life planning, and we don't want to discourage that by using it in a way that would go beyond what it's used for.
After the arrests, the person who had to prosecute this case before the grand jury -- a young prosecutor in Orleans parish -- he really struggled before the grand jury that was going to look at whether second degree murder charges would be brought to trial, and he told me like he felt like he was applying justice to a war zone. The forensic experts that this coroner brought in, they basically, almost to a one -- there was one who disagreed -- but the others, they all felt that the pattern of the deaths…

One wrote that all these patients survived the adverse events of the previous days. For every patient on a floor to have died in one three-and-a-half-hour period with drug toxicity is beyond coincidence. They felt these were homicides, at least medically speaking without regard to criminal intent. Technically they felt that these were deaths caused by human intervention. Another of the experts brought in felt like the bodies had stayed too long in the heat and you couldn't draw any conclusions from them.

This prosecutor had to go in front of the grand jury. He felt he was trying to apply justice to a war zone. After all, top hospital officials knew the hospital's electrical system was vulnerable to flooding. The corporate owners, who were in Texas, had waited a whole day before they realized, "We've got to hire helicopters and try to get these people out because the governmental response isn't adequate to get them out quickly." Of course the levees were faulty. There have been all sorts of lawsuits about that.

The government rescue efforts, even though brave, brave people who flew those helicopters, just weren't enough. However, of course, we do have laws in war zones, and these problems often do crop up in disasters. As I've seen everywhere I've worked, systems almost inevitably fail. We can't know what choices we would have made in this disaster, but unlike these exhausted staff members, we can think in advance about what choices we would want to make if we ever faced a disaster, and of course there's all sorts of levels of that.

Improvements in infrastructure, possibly requiring disaster training of our medical and nursing professionals, things about leadership structures in hospitals down to individual decisions, and of course also I think a more inclusive process for bringing the public into some these, setting guidelines that can help decision-making in acute disasters.

In the end, what happened was that nobody served jail time. The nurses were given immunity to testify at the grand jury and they were not prosecuted, but they spoke in the grand jury of the doctor's case, and she was not indicted, and all of them are back to work. As far as I know, they have full rights to practice, including giving narcotics, and there was a huge-- I should say the public support in New Orleans was great for these health professionals, was very high.
Because of all those layers of failure that I mentioned, people felt that it was wrong that a doctor and two nurses who, by all accounts, had worked very hard in the storm, had had no nursing discipline in the past, had worked for decades -- these were some of the top, top nurses at this facility -- and so people felt outraged. Of course, most people didn't even believe the rumors that something like this had happened, but they also just felt like in the context in which it occurred that these people shouldn't face jail time for the rest of their lives. So there was a huge amount of public support for them, and a lot of pressure on the prosecutors to let this go.

In fact, the prosecutor told me that he did something very unusual he'd never done in another case, which is that he let the grand jury run its own investigation. In other words, he didn't go in there and say, "You've got to indict." He said, "You guys tell me what you want to hear. We're going to bring the people in, the experts," and they didn't hear from all the experts, but some of them, "and then you guys make the decision," and that was unusual.

After the resolution, staff at Memorial sued under pseudonyms -- Jane and John Does -- to prevent the state from releasing its investigative records to the public, because there was a huge amount of media interest in this, as well as some of the family members who had civil suits. They wanted that as well, and so there was this court case. Interestingly, the Louisiana board of nursing intervened in the case, and they were asserting their rights to access these records, and they wrote...

In court, Wade Shows, who is the attorney representing the board -- some of you may know him -- he said to a judge at a hearing, "As a regulatory body, we have an independent responsibility and duty to look at the activities that the nurses may have been involved in. We wanted to intervene in this case to make sure that we have access, if necessary, to any of the records that may be subject to this particular litigation."

He said that they had an independent duty and responsibility to investigate and possibly bring disciplinary actions against any happenings that may have occurred of a professional nature, including potential violations of the nurse practice act. They weren't saying that something had occurred, they were saying that they had the duty to investigate that. Maybe if some of our Louisiana colleagues are here, they might know whether they ever got access to those records that they had asked for, but the records were in general sealed, and they were not given to the media and to others.

It all came down to the question of whether there was potentially further action, and the court was convinced that this case could be reopened at any time. In fact, they used an article that I wrote in 2009 about this, where Dr. Cook, his case hadn't been known before, and they said, "Any time something like that could come to the
public, we might need to investigate. Therefore, all these need to remain sealed," and so they remain sealed to this day.

I want to end with some positive notes about good things that both were done at this hospital and that have come out since then. In some ways a lot has changed since Katrina. Health care coalitions are increasing. These are disaster-based coalitions and they're working in coordination with partners across government and across different sectors of the public to try to prepare for disasters and really talk to each other and know who we are in advance of a disaster, and there's a lot more coordination going on. A lot has been learned about that.

This year the Joint Commission has added a leadership component to its emergency preparedness standards, recognizing that the c-suite has a real role to play in preparedness, and of course the CMS' proposed rule has just come out. But of course challenges remain. I think that our American infrastructure is so very vulnerable. Whether it's flooding, earthquakes, etc., we really...it costs so much to retrofit hospitals, and it's really not done.

The example of California, 1974, I think -- the Sylmar earthquake. People died in hospitals there. The state decided that there needed to be much stronger seismic standards for hospitals. Of course we want them to not only protect our patients and our staff, but serve as a resource for a community in a disaster. So there are new building standards, but the old hospitals, which had a short period or what became a very long period -- it's been more than 40 years and they're still being allowed to have more years to retrofit, because it's incredibly expensive.

In New York there's a proposal out for our hospitals to have to be made more invulnerable to flooding, and again, 15-year time period is being set, and I imagine as the time gets closer to those 15 years, we may see extensions of that. So we have these vulnerabilities. Communications and records are, in most places, going to be real problems in disasters. Hard for you guys when you're investigating something, when people don't have time to or don't have a computerized system to make their notes.

Lack of preparedness for total power, lack of data on whether evacuating or sheltering in place makes sense, a public disengagement on preparedness, dwindling funding for these kinds of things, more and more people in the community with medical and nursing needs, and so I think it's really important that we engage more with the public and even get some of these uncomfortable vulnerabilities out in the public eye so that we know about them.

And we must remember that disaster plans always have to change, and that maintaining flexibility and creativity and fighting for more resources can really save lives. I want to point out how that happened at Memorial. This is Mark and Sandra LeBlanc. His mother was on life care. She's an EMT and they were outside of New Orleans when the storm hit, and they fought their way past checkpoints. It
was actually hard if you wanted to come into the city to help, and they helped to
direct some Louisiana volunteers from the western Louisiana swamplands.
They had flat-bottomed boats, and this is them pulling up to the emergency room
ramp, and they got a lot of people out of the hospital this way, saving not only their
mom but other people, too, and you can see one of the doctors here is holding onto
the emergency room ramp. That's the top of the ramp, and they're passing people
down into the boats and then taking them over to safety, or actually this was a big
question. Would they go to safety? They actually just went eight blocks away to
dry ground, and then people had to wait and see whether ambulances would come,
etc. That was a whole other layer, and the nurses were very conscious of "where
are we sending our patients? Should we allow them even out of this hospital?"
This is a really heroic story. I told you about the NICU being evacuated, and what
happened was that when those helicopters were supposed to come that first night,
the ones that were supposed to come with all the medical bells and whistles didn't
come first. They had these small helicopters that couldn't fit some of the
sophisticated machinery keeping some of the most vulnerable babies alive,
including these large incubators. So at one point you prepare, you plan, and then
you improvise.
This nurse on the left and the doctor on the right, they literally tucked themselves
into this helicopter, held onto those babies, hand-ventilated them all the way to
Baton Rouge, and saved those lives, and they saved all 20 babies. This doctor, he
was born in Argentina, and he had earned the nickname "the Argentinean
Kangaroo," because at one point he stuck the baby under his scrub shirt and that's
how he kept it warm and safe.
He told me that this baby, who's now a boy in Texas, comes back every year to
thank his nurses and doctors for saving his life. He and his mom come back, and
that's the kind of life-saving work that was done at this hospital that often gets
overshadowed by the sad things that happened there.
Also creative thinking again -- people realized there was a hole in the machine
room wall, this little opening that had been made during construction presumably.
It led into the parking garage, and literally they passed patients through this way,
then they drove them on the back of a pickup truck to the eighth floor of the
hospital's parking garage, and then they carried them up these rickety flights of
step.
Each patient who was very sick had to be brought up these steps to the helipad
which hasn't been used in many years, was marked for the name of Southern
Baptist Hospital -- "SBH" -- so it was even hard for helicopters to find them, and
this is how that looked at the time. Amazing work, and in the heat, carrying people
up to this helipad.
Again, just incredible, incredible work that was done. Let's go back and end with Bellevue Hospital. Where I left you, this doctor was facing this really tough decision, and this is again some of these outlets that were being wired to the ICU. The surge of water from the East River was filling up the basement. Most of their generators were on the 13th floor, but the fuel pumps were down near where the fuel tanks had to be by law kept below ground level, and they were not protected against floodwaters.

That was going to be knocked out. They thought they had about an hour of power left. This doctor had actually learned something from Katrina. She knew this case, and she told me a few things. First of all, she decided that choosing which patients would be taken first was not the choice of one doctor, so she got together a group of people to make this decision, and they were not going to be caregivers of those particular patients.

She felt that a nurse, a doctor who is caring for a patient -- it's their duty to advocate for that patient, so she got all people who didn't have patients on her ICU to help make this decision. And then she wanted some way to prove the next day, the day after -- she was thinking about how will this look the day after? How will I explain this to society? I want to do this in a transparent way, in some sort of way that I can defend. She even went so far as to think about what would the New York Post headline would look like.

We're famous in New York for our New York Post sensationalist headlines, so she was like, "What rhymes with my last name?" She was Evans, she was thinking heavens.. She really said she thought about these things, and what New York City had done -- New York state, actually -- was that they had come up with ventilator triage protocols in case of a terrible pandemic. This came out of SARS, and H1N1. There was a renewed interest in coming up with these protocols.

Heaven forbid we have a 1918-style flu pandemic. We'll have far more people who are sick who need ventilators than we have nursing staff, ventilators themselves. How do we pick? Of course now we know, after H1N1, a lot of those initial efforts to come up with these standards, which were based on [inaudible 01:02:21] scores and things actually wouldn't-- It turns out research shows they probably wouldn't be terribly good at predicting who would benefit, but it was something objective that she could use, and she repurposed that to try to come up with who should be prioritized for the power outlets.

She did all of this -- the committee did -- coming up with the decision, who the six patients were, moving them to the right beds, and then she did more. They weren't going to give up on those other patients. She stationed a nurse by every bedside of a patient on a vent, ready to ambu-bag, and the one thing that she said they didn't do and she felt was their ethical duty to do and she found just too hard -- and she said, "I chickened out" -- was to face the families and say, "This is what we're
doing, and, by the way, your mom isn't one of our six." The idea of how do you even face somebody and let them know that is a really tough thing, but she felt like it's something we need to talk about, we need to figure out how to do. What really saved lives, though, as some of you might know the story -- and this is a picture I took of incredibly this evacuation of Bellevue Hospital. I think it took as many days as Memorial Hospital in New Orleans, even though the water came and it went in New York, but they had something like...I think it was 1,000 patients. It's like a 26-story hospital, and they had to take them all down by the steps because the elevator banks filled with water. This is how that looked, strikingly like Katrina: Flashlights in the dark stairwells. What really saved lives was that creative thinking, and somebody realized that even if the fuel pumps were knocked out, if they hand-carried fuel up -- and they literally passed it up, you should've smelled the staircases where this was done -- hand-carried the fuel up to the 13th floor, they could keep those generators running and keep partial power to the hospital until they got every single patient out, and they did that. I have to say, one of the last two patients was a man who was far heavier than Emmett Everett, and they kept passing those fuel buckets up, fuel containers, first just volunteers. National Guard got into the action for a couple of days until they could get one elevator working, and they got him out and they got him to safety. I think we learned a little something from Katrina, and I think that is really the goal. Sometimes when it seems like we only have bad choices, sometimes if we can possibly think beyond -- and it's really, really hard to do in a disaster -- sometimes there's a third choice that prevents those really awful choices from being made, and so I wanted to leave you with that inspiration, and I'll also just say please get in touch. As was mentioned, I'm now at the New York Times. I'm currently working on stories about drug shortages. If you face those, I'd love to hear from you. Another form of triage, unfortunately, that's happening in America, but really feel free to get in touch. I salute you for what you do, and I look forward to our question-and-answer, so thanks. (Clapping.) Audience Member: I'm the director of investigations. I can say I've never read the book, so I can't speak to the book yet. I was not at the board. None of us were actually at the board during this time frame. I did work in Baton Rouge in the emergency room and we did receive a lot of the patients and so forth, and I know there were investigations. Mr. Wade Shows is still there at the board. I do not know the outcome of that question you asked earlier. I have not gone back and looked at any of those cases, but it was a tragedy and a disaster. Moderator: [01:06:14] question, we did ask the Louisiana board to make a response, and they were not able to make one today.
Speaker: I should say that the staff who worked at the hospital have been incredibly supportive of the book. I had several public events in Louisiana, and what was amazing was that doctors came, nurses came, administrators came, patients who survived came, as well as some of the people who lost loved ones, and we had a really interactive discussion. When I asked those questions to you and those audiences, I just let people talk, and it was a respectful discussion, and afterwards some of the...in particular a woman who lost her mom, whose mom was one of the ones who died, who had totally lost her faith in hospitals, nurses, doctors, and one of the nurses from life care who had never gotten over her guilt at her patients dying -- they went out for a coffee after, and it was so incredible, because I think there's been a lot of pain. There's been a lot of...these were traumatic events. They were all over the media. There were arrests, there was a breach of trust between different communities, and I hope that the book can be a tool of healing, and so far most of what I've heard -- I think the doctor who was arrested has come out strongly against any discussion of this, all media attention, my article, my book, but aside from a few people like her who clearly have an interest... There's no statute of limitations on murder. These people have to defend themselves. It's understandable. I should also say that they've insisted always, unlike the doctors who spoke with me and said, "We intentionally hastened death," the people who were arrested always said, "We did this for comfort," and of course we have this idea of the double effect, which is if you give drugs that could cause death but your goal is to produce comfort, then that's considered ethical, that's considered legal, and so a lot of things turn on that question of intentionality. So they have described their intentions as merciful, as comfort, but that's just to give you a sense of the feedback I've gotten from people in Louisiana has been amazingly positive.

Audience Member: Hi, Dr. [inaudible 01:08:48], thank you. Name's Donald McCall, compliance [inaudible 01:08:51], Louisiana state board of nursing, and during the time and event I was a deputy coroner for one of the local parishes, and one of the patients who didn't make it, her daughter was a childhood friend of my wife and I. Through the entire event, we supported the facility. Of course the daughter didn't understand and [inaudible 01:09:13] as part of the grieving process. I look forward to reading your book, and I just want to let you know that I very much look forward to reading the book and have always supported what happened in the hospital, being that I worked for the coroner's office as well as law enforcement and prior to that I was a paramedic before I was a nurse. I relayed these events to the daughter, and it's been nine years now and we still talk about it. It was trying times because she lived with us for four to six weeks.
afterwards, and I only lived maybe three miles from the morgue that they had set up at the Hansen Center, and it took me that long before I could get her to go there and…

Speaker: Identify her mom?
Audience Member: Yes. [inaudible 01:10:00] forward to that, and that was a very touching day, and I thank you very much.

Speaker: This is a great question: Did anyone volunteer to be left behind or take care of everybody else first? You mean among staff, or patients, or…?

Audience Member: Either one, but I'm interested in patients or patients' families [inaudible 01:10:20]...

Speaker: Yes. This is a really interesting question. My mom -- she died of cancer, and I could imagine toward the end she might have said, "Take everybody before me." This question of triage and did they make the right or wrong decisions, but there's not an easy answer to sickest first, last. But this question of can you bring the patient or the family member input into it, I think you can. I think it's hard, but I think you can and I think you should if you can.

A great example was the hospice at Branford, Connecticut. They had to evacuate for Sandy somewhat urgently. They're on the water, and they were going to take the sickest first, the people closest to death, but they turned around, and before they moved people, they actually asked the families, and they found out something surprising, which was that the families and, "Our loved one chose to die at hospice. That is our wish, and so therefore we want everybody else to go first because then our mom will have the greatest chance of dying here if she has more time here."

It was interesting. They reversed the evacuation order based on input, just like you said, by actually asking the families, and they were able to do that in a time of crisis. They ended up being able to move everybody, but I thought that was an interesting example of where you could get input, and there have even been some thinking about could you consent people when you're doing your DNR. Could you ask about disaster preferences? It's a valid question.

Actually, interestingly, Anna Poe -- the doctor who was arrested -- she recently gave a talk on ethics at the Joint Commission meeting on disasters two weeks ago, and I had been invited to attend the meeting, and somebody asked her that question, was there any consent. He didn't specifically ask if like, "When you went into Emmett Everett's room, as people have said they witnessed you do, did you ask him?"

He just asked it in a general way, and she indicated that there wasn't an aspect of what they did, but there were family members there, and the book tells the story of a couple daughters who were present. We all know those family members, those caregivers who just do not leave their loved ones' side throughout the whole
hospitalization, and there were a couple of those, more than a couple, but a couple in the book.
They were not asked before this happened. They were told to leave. It's not clear whether they were told to leave because this was about to happen, or just because that was the moment when was screaming, "Women and children!", and everybody had to leave, but they were ushered out and they were never asked.
Moderator: Thank you very much for coming today.
Speaker: Thank you. Thanks so much.
(Clapping.)